MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05737

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:
County: Balto.
City or town: Woodensburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 weeks
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Near Reisterstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Emma Bell Allender

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Ernest Allender
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): May 20, 1883

8. AGE: Years	Months	Days	If less than one day
64	2	8	hrs. min.

9. Birthplace: Balto. Co. (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business

FATHER
12. Name: Myers
13. Birthplace: Md.

MOTHER
14. Maiden name: Clara Myers
15. Birthplace: Md.

16. Informant: Mrs. Hazel Keller
Address: Reisterstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 30, 1947 (month) (day) (year)
Cemetery or crematory: St. Paul
Location: Balto. Co.

18. Funeral director: J. F. Eline & Sons
Address: Reisterstown, Md.

19. July 30 1947 (Date rec'd by registrar) Mary B. Eline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 28 1947 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-2- 1947 to 7/28/1947 and that I last saw h[illegible] alive on 7/27/47 1947

Immediate cause of death	DURATION
Sarcoma of uterus	1 yrs
Due to	
Due to metastisis & cachexia	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James G. Sallell M. D. or other
Address: Reisterstown Md Date signed 7/30/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

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AUG 2 1947

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 183

CERTIFICATE OF DEATH

05738

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Balto
City or town Lansdown (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Wm Kraemers Pond
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md County
City or town Balto (If outside city or town limits, write RURAL and give nearest town)
Street No. 1910 E Lombard St (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mr Julius Alston
3.(b) Social Security Number 216-16-9651

4. Sex M
5. Color or race C
6.(a) Single, married, widowed, or divorced Single
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) Feby 2 1923
8. AGE: Years 24 Months 5 Days 24 If less than one day ... hrs. ... min.
9. Birthplace Littleton N C, (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business
FATHER 12. Name Rey Alston
13. Birthplace N C
MOTHER 14. Maiden name Mateldia Watson
15. Birthplace N C
16. Informant Mateldea Watson (Mother)
Address Littelton N C
17. Burial (Burial, cremation, or removal) Date thereof July 28th/47 (month) (day) (year)
Cemetery or crematory Littelton N C
Location N C
18. Funeral director Elroy O Wilson
Address 1000 Brantley av.
19. July 28 1947 (Date rec'd by registrar) G. Kieffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1947 at 7:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death Drowning	
Due to swimming in pond	
Due to	
Other conditions accident	

(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide accident Date of July 26 47
Where did injury occur? Lansdown Balto Md (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) public place
Means of injury swimming in pond Injured at work? no

23. SIGNATURE G. Kieffer Dep Chief Med Exam M. D. or other
Address 1040 Lexdon av Date signed 7-26-47


RECEIVED
JUL 30 1947
BUREAU

Evidence for the addition of year of birth and age is shown on G 111 8/7/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

47a

05739 f

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:
County: Baltimore
City or town: Sparrows Point - 19 -
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 months.
Hospital, institution, or street address where death occurred: 7415 North Point Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Baltimore
City or town: Sparrows Point - 19 -
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2638 Maretha Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3. (a) FULL NAME: GRANVILLE LESLIE AMOS

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Widowed.

6.(b) Name of husband or wife: Elizabeth Allen Amos
Amos. 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Jan 26 1875

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
72	6	5		

9. Birthplace: Orange Co. Va.
(Town, county, and state)
10. Usual occupation: Electrician.
11. Industry or business: Steel Industry.

FATHER
12. Name: Garrett Amos
13. Birthplace: Va

MOTHER
14. Maiden name: Martha Frances Shipp.
15. Birthplace: Va

16. Informant: A. Blanche Rumble
Address: as in #1.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 3/47 (month) (day) (year)
Cemetery or crematory: Ebenezer Meth Epis
Location: Balto Co Md
18. Funeral director: Philip Herwig Sons
Address: 2024 Eden St

19. 8/1 1947 (Date rec'd by registrar) C-W Herwig M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 31 1947, at 3.38 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1946, to July 31 1947.
and that I last saw him alive on July 31 1947.

Immediate cause of death	DURATION
Adeno carcinoma of Larynx.	1 yrs.
Due to	
Due to	
Other conditions: Tracheal intubation	11 months.
Gastrostomy	4 months

(Include pregnancy within 3 months of death)

Major findings of operations: Adeno Carcinoma of Larynx. Johns Hopkins Hosp.
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Louis H. Sodini. M.D. M. D. or other
Address: Sparrows Pt Md Date signed 7/31/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

05740

CERTIFICATE OF DEATH

Reg. Diat. No. 37

1. PLACE OF DEATH:

County: Baltimore

City or town: Texas

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yr. 10 mo. 9 da.

Hospital, institution, or street address where death occurred:

Baltimore County Home

How long in hospital or institution? 2 yr. 10 mo. 9 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Hebbville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 9

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: Charles Arndt

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	—

6.(b) Name of husband or wife:

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Mar. 22, 1876

8. AGE: Years	Months	Days	If less than one day
71 yr	3	24	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER — 12. Name: Frederick Arndt

FATHER — 13. Birthplace: Germany

MOTHER — 14. Maiden name: Henrietta ?

MOTHER — 15. Birthplace: Unknown

18. Informant: Balto. Co. Home Register

Address: Texas. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 7-17-47 (month) (day) (year)

Cemetery or ~~crematory~~: Baltimore Co. Home

Location: Texas Maryland

18. Funeral director: Landon M. Brooks

Address: Sparks Md.

19. July 16 1947 (Date rec'd by registrar) Wm J Whitcomb Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 16 1947, at 11 25 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 7 1938 to July 16 1947

and that I last saw him alive on July 16 1947

Immediate cause of death	DURATION
Coronary Thrombosis	2 days
Due to: Arteriosclerosis Mellitus	
Due to:	
Other conditions: Both legs amputated at knees	

(Include pregnancy within 3 months of death)

Major findings of operations: Operations: 1938 & June 1940 due to gangrene and arteriosclerosis

Date of op. E 9/17/1940

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Hilmer C. Enos M.D. M. D. or other

Address: Cockeysville Md. Date signed 7/16/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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JUL 24 1967
BUREAU V.A.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

70 05741

Reg. Diat. No. 41

P

1. PLACE OF DEATH

County Balto.

City or town Dundalk

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

22 Norris Lane.

How long in hospital or institution? (4 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.

City or town Dundalk

(If outside city or town limits, write RURAL and give nearest town)

Street No. 22 Norris Lane.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Bobby Thomas Banks.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Single.

6.(b) Name of husband or wife (Mother) Ruth Banks.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 25 46

8. AGE: Years 1 | Months 2 | Days 1 | If less than one day ..... hrs. ..... min.

9. Birthplace Churchland Va.

(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name John Banks.

13. Birthplace Va.

MOTHER 14. Maiden name Ruth Williams.

15. Birthplace Va.

16. Informant Virgie Williams.

Address 22 Norris Lane, Dundalk Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 29, 1947 (month) (day) (year)

Cemetery or crematory

Location Virginia.

18. Funeral director Elroy D. Wilson

Address 1010 Bentley ave

19. 7-28-1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1947 at 8:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 26 1947, to July 26 1947

and that I last saw ..... alive on ..... 19.....

Immediate cause of death	DURATION
Congenital Heart	3 days
Due to	
Due to Rickets.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J. M. Carmine M.D. M. D. or other

Address Dundalk, Md. Date signed 7/29/47.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Sp. Pt 26

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

05742

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: North Bend

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 mos

Hospital, institution, or street address where death occurred: North Bend Rd Hood Nursing Home - Edmondson Ave

How long in hospital or institution? 4 mos

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: —

City or town: Mt Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1207 Belvedere Ave

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME Pauline Barry

3. (b) Social Security Number 212-10-3122

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 6 1873

8. AGE: Years: 73 | Months: 11 | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Balto. Md.

(Town, county, and state)

10. Usual occupation: Clerk.

11. Industry or business: Md. Casualty Ins. Co.

FATHER — 12. Name: James Casey Barry

FATHER — 13. Birthplace: —

MOTHER — 14. Maiden name: Josephine Barry

MOTHER — 15. Birthplace: —

16. Informant: Mrs. Samuel A. Tubman

Address: Ruxton Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 4 1947 (month) (day) (year)

Cemetery or crematory: New Cathedral

Location: Balto Md

18. Funeral director: Henry W. Jenkins & Sons Co

Address: McCulloh & Orchard Sts

19. 7/3 1947 H. W. Hedrick Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 2 1947, at 3 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15 1947, to July 2 1947

and that I last saw h[er] alive on July 2 1947

Immediate cause of death: Cerebral Hemorrhage — DURATION: 3 days

Due to: Arteriosclerosis

Due to: —

Other conditions: —

(include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: James R. Fowler M. D. or other

Address: Towson Md Date signed 7-9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Dr. J. S. Howell
715 Frederick Ave

05743

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 33

1. PLACE OF DEATH:

County Baltimore

City or town Gwynnbrook Ave. Owings Mills

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Balto.

City or town Gwynnbrook Ave Owings mills.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Dewey Baublitz

3.(b) Social Security Number 219-20-5264

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	M

6.(b) Name of husband or wife Bessie M Whitcomb.

6.(c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) June 30, 1901

8. AGE:

Years	Months	Days	If less than one day
46	1		hrs. min.

9. Birthplace Glyndon, Md. (Town, county, and state)

10. Usual occupation Laborer.

11. Industry or business

FATHER 12. Name Fred Baublitz

13. Birthplace Glyndon, Md.

MOTHER 14. Maiden name Katie Shaffer

15. Birthplace Greenmount Carroll Co. Md.

16. Informant Fred Baublitz

Address Owings Mills

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 2, 1947 (month) (day) (year)

Cemetery or crematory All Saints

Location Bond Ave. Reisterstown.

18. Funeral director Wm. Berryman & Sons

Address Reisterstown, Md.

19. Dec 1 1947 (Date received by registrar) Mary B. Eline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/30/1947 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/1/47 to 7/30/47

and that I last saw him alive on 7/30/47

Immediate cause of death	DURATION
Acute Coronal Thrombosis	Years
Due to Arteriosclerotic disease	
Due to —	
Other conditions Luea - tertiary	Yrs.

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James G. Lobell M. D. or other

Address Reisterstown Md. Date signed 7-31-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
AUG 7 1947
BUREAU OF S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

05744

CERTIFICATE OF DEATH

Reg. Diat. No. 42

1. PLACE OF DEATH:

County Balto.

City or town Arbutus Halethorpe

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 yrs

Hospital, institution, or street address where death occurred:

4806 Benson ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Balto

City or town Arbutus

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4806 Benson ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME August Baumgartner

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife Laura Baumgartner

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) aug 1 1865

8. AGE: Years 81 | Months 11 | Days 22 | If less than one day ..... hrs. ..... min.

9. Birthplace Balto md

(Town, county, and state)

10. Usual occupation Butcher

11. Industry or business

FATHER 12. Name unknown

13. Birthplace unknown

MOTHER 14. Maiden name unknown

15. Birthplace unknown

16. Informant Louis Baumgartner

Address 4806 Benson ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-26-47 (month) (day) (year)

Cemetery or crematory Mt Olivet

Location Balto md

18. Funeral director George L Schmidt

Address 701 Frederick ave

19. July 26 1947 (Date rec'd by registrar) Geo McKieffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24 1947 at 11:25 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
a fib	
Due to	
Cardiovascular disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE Geo McKieffer Dep Med Exam Balto M. D. or other

Address 1010 Leadenhall Date signed 7-26-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JUL 28 1947
BUREAU [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1054 93d

Reg. Diat. No. 0574538

1. PLACE OF DEATH:
County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 Years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No. 503 Carla Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Elizabeth Douglass Bennett

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widowed

6.(b) Name of husband or wife: Maurice M. Bennett
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Mar. 31, 1859

8. AGE: Years	Months	Days	If less than one day
88	3	4	hrs. min.

9. Birthplace: Carbondale, Penna. (Town, county, and state)
10. Usual occupation: Homemaker
11. Industry or business

FATHER
12. Name: William Scott
13. Birthplace: New York

MOTHER
14. Maiden name: Elizabeth Douglas Scott
15. Birthplace: Carbondale, Pa.

16. Informant: Mrs. Benj. H. Engle
Address: 510 Carla Ave Towson

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/7/47 (month) (day) (year)
Cemetery or crematory: Forest Hill
Location: Scranton, Pa.

18. Funeral director: Landon M. Brooks
Address: Govans Md

19. 7/5 1947 (Date rec'd by registrar) Darrell Fantom Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 4th 1947 at 6 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from before 1947, to July 4 1947, and that I last saw h[illegible] alive on July 4 1947.

Immediate cause of death	DURATION
Myocardial insufficiency	
Due to General Arteriosclerosis	
Due to Hemiplegia	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Daniel J. Shoemaker M. D. or other
Address: Towson 4 Md Date signed 7/5/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The coverage is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
AUG 4 1947
BUREAU OF S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05746 Reg. Dist. No. 33

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Reisterstown
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Int. & Peasant Sanatorium
Stay in hospital or inst. (yrs., or mos., or days): 14 months
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore City
City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 5401 Nelson Ave
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Jason Bers

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

B (b) Name of husband or wife:
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 16, 1865

8. AGE: Years	Months	Days	If less than one day
81	11	3	hrs. min.

9. Birthplace: Russia (Town, county, and state)
10. Usual occupation: Baker
11. Industry or business

FATHER
12. Name: Israel Bers
13. Birthplace: Russia

MOTHER
14. Maiden name: Hannah Moronstein
15. Birthplace: Russia

16. Informant: Jessie Backmid (daughter)
Address: 5401 Nelson Ave Balt. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 19-47 (month) (day) (year)
Cemetery or crematory: D.C. Lodge Cemetery
Location: Washington D.C.

18. Funeral director: Jake Segars
Address: 1439 E Baltimore

19. July 19 1947 (Date rec'd by registrar) Mary B. Eline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 19, 1947, at 8:10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 24, 1946 to July 19 1947, and that I last saw him alive on July 19, 1947.

Immediate cause of death	DURATION
Myocardial failure	
Due to Cerebral Hemorrhage.	3 Days
Due to Pulmonary Tuberculosis	20 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Albert F. Shuri MD
M. D. or other
Address: Reisterstown Md. Date signed 7/19/47

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JUL 22 1947
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

05747

Reg. Dist. No.

1. PLACE OF DEATH:
County: Baltimore
City or town: Inverness
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 weeks
Hospital, institution, or street address where death occurred:
525 Bayside Drive
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No. 608 Baltimore Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: MARY ELLEN BOLTON

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: William P. Bolton
6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): June 29, 18 86

8. AGE: Years	Months	Days	If less than one day
61	---	21	....hrs. ....min.

9. Birthplace: Towson, Balto. Co., Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: At Home

FATHER
12. Name: Thomas Lloyd
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Ellen Cronin
15. Birthplace: Maryland

16. Informant: William P. Bolton
Address: 525 Bayside Drive, Inverness, Balto. Co., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 23, 1947 (month) (day) (year)
Cemetery or crematory: Mt. Maria Cemetery
Location: Towson, Maryland

18. Funeral director: John Burns' Sons
Address: Towson, Maryland

19. July 22 1947 (Date rec'd by registrar) C. W. Hydrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 20, 1947, at ....M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 27 1947, to July 20 1947
and that I last saw her alive on July 20 1947

	DURATION
Immediate cause of death: CHRONIC MYOCARDITIS	7
Due to: 1. Cerebral Accident	7 mos
2. Coronary Occlusion	4 mos
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: M Davis M.D.
M. D. or other
Address: Dundalk Md. Date signed 7-22-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

124 b

05748 32

Reg. Dist. No.

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Pikesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Balto.

City or town: Pikesville (If outside city or town limits, write RURAL and give nearest town)

Street No. 17 Brightside Ave. (If rural, give LOCATION)

2.(a) If veteran, name war: NO

3.(a) FULL NAME: Herbert G. Bowen

3.(b) Social Security Number: NO

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lottie M. Bowen

6.(c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): February 12, 1879

8. AGE: Years	Months	Days	If less than one day
68	4	26	..... hrs. ..... min.

9. Birthplace: Towson, Md. (Town, county, and state)

10. Usual occupation:

11. Industry or business: Towson Court House

FATHER — 12. Name: John W. Bowen

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Anna Herbert

MOTHER — 15. Birthplace: Maryland

16. Informant: Thelma Bowen

Address: 17 Brightside Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 11, 1947 (month) (day) (year)

Cemetery or crematory: Druid Ridge

Location: Pikesville, Md.

18. Funeral director: George W. Little

Address: 2700 Edmondson Ave.

19. 7/10 1947 (Date rec'd by registrar) A W Hedrick Registrar

DN

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 8, 1947 at 10.15 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 12 1946 to July 8th 1947 and that I last saw him alive on July 8th 1947

Immediate cause of death	DURATION
Chronic Myocarditis	8 mons.
Due to: Cirrhosis of Liver	1 yr.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: James G. Miller M.D. M. D. or other

Address: Pikesville-8, Md. Date signed: 7/9/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

50 05749

Reg. Diat. No. 37

1947
43

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Cockeysville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Cockeysville (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Masonic Home
(If rural, give LOCATION)
2.(a) If veteran, name war: Former residence Sidney, Me.

3.(a) FULL NAME: Genevieve Florence Bowman

3.(b) Social Security Number: 263-24-8529

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Married

8.(b) Name of husband or wife: Wm. Reginald Bowman
8.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): June 30, 1904

8. AGE: Years	Months	Days	If less than one day
43	1	16	— hrs. — min.

9. Birthplace: Stratton, Maine (Town, county, and state)
10. Usual occupation: Trained Nurse (Reg.)
11. Industry or business

FATHER
12. Name: Ira C. Taylor
13. Birthplace: Copland, Maine

MOTHER
14. Maiden name: Mary J. Faught
15. Birthplace: Maine

16. Informant: Wm. R. Bowman
Address: Cockeysville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 19, 1947 (month) (day) (year)
Cemetery or crematory: Funkstown M. E. Cemetery
Location: Funkstown, Maryland

18. Funeral director: Landon M. Brooks
Address: Sparks, Md.

19. 7-16 (Date rec'd by registrar) 19 47 Wilmer C. Ensor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 16 19 47, at 11 40 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15- 19 47, to 7/16 19 47 and that I last saw h[illegible] alive on 7/15- 19 47

Immediate cause of death	DURATION
Carcinoma - (Brain)	3 mo.
Due to: Primary site: Breast [7/17/47 dea]	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Left breast removed - 15-mo. ago Date of op. 2/15/46.
Autopsy results: Womans Hosp. Balto. Dr. [illegible]
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Wilmer C. Ensor M. D. or other
Address: Cockeysville Md. Date signed: 7/16/47.

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JUL 18 1947
BUREAU V B

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

952

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CERTIFICATE OF DEATH

Reg. Dist. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A-1 9-45-15M

1. PLACE OF DEATH:
County ~~Howard~~ Balto. COUNTY
City or town CATONSVILLE, MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 DAYS.
Hospital, Institution, or street address where death occurred:
HOME IN PINES NURSING HOME
How long in hospital or institution? 16 FOSTING AVE. 2 DAYS.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County WICOMICO
City or town MARDELA SPRINGS, MD
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME MAGGIE B. BRADLEY

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOWED.

6.(b) Name of husband ~~or wife~~ GEORGE O. BRADLEY
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) JULY 8, 1869

8. AGE: Years	Months	Days	If less than one day
78		16	..... hrs. ..... min.

9. Birthplace MARDELA SPRINGS, MD.
(Town, county, and state)
10. Usual occupation HOUSEWIFE
11. Industry or business —

FATHER
12. Name WM. B. BOUNDS
13. Birthplace ?

MOTHER
14. Maiden name ELIZABETH BOUNDS
15. Birthplace MARYLAND

16. Informant MRS. M. K. KINSEY
Address 1221 ROUNDHILL RD. BALTO

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/27/47 (month) (day) (year)
Cemetery or crematory Mardela Springs
Location Mardela Springs Maryland
18. Funeral director Gravenor Brothers
Address Sharptown, Maryland

19. July 25 1947 (Date rec'd by registrar) A. W. Jedrich Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24, 1947, at 2 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 26, 1947, to July 24 1947 and that I last saw h.E.R. alive on July 23, 1947

	DURATION
Immediate cause of death CORONARY THROMBOSIS	1 MO.
CARDIAC DECOMPENSATION,	
Due to ACUTE	
Due to	
Other conditions ARTERIOSCLEROSIS,	?
GENERALIZED SENILITY.	

(Include pregnancy within 3 months of death)

Major findings of operations NONE — Date of op.
Autopsy results NONE.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Arthur Karfgin M.D. M. D. or other
Address 4230 LOCH RAVEN BLVD. Date signed 7-24-47.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

C5750

183

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: ~~Breezy~~ Point - Baltimore
City or town: Middle River (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Breezy Point
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Balto
City or town: (If outside city or town limits, write RURAL and give nearest town)
Street No.: (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Sherman LeRoy Brick
3. (b) Social Security Number

4. Sex: M
5. Color or race: W
6.(a) Single, married, widowed, or divorced: M
6.(b) Name of husband or wife: Elizabeth Brick
6.(c) If alive, give age: 24 years
7. Birth date of deceased (mo., day, yr.): Aug 26 - 1921
8. AGE: Years 25, Months 10, Days —; If less than one day ... hrs. ... min.
9. Birthplace: Berlin Pa. (Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business: Samuel E. Dixon
FATHER 12. Name: Allen Brick
13. Birthplace: Unknown
MOTHER 14. Maiden name: Susan Hostetter
15. Birthplace: Unknown
16. Informant: Samuel Dixon
Address: 118 N. Washington St.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 9-47 (month) (day) (year)
Cemetery or crematory: Mt Carmel
Location: O'Donnell St. Rd.
18. Funeral director: Wm. Cook, Inc.
Address: St. Paul & Preston Sts.
19. July 6 1947 (Date rec'd by registrar) John B Carroll Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 6th 1947 at 12 Noon
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death: Drowning — (DURATION)
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: Jly 6-1947
Where did injury occur: Breezy Pt Middle River Balto Md (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Public Place
Means of injury: [illegible] Injured at work? No

23. SIGNATURE: M. B. Davis M.D. (M.D. or other)
Address: [illegible] Date signed: 7/6/47

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JUL 21 1947
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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. pc 05754

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 28 days
Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Ft. Howard, Md.
How long in hospital or institution? 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 931 Eden Street
(If rural, give LOCATION)
2.(a) If veteran, name war: WW I

3.(a) FULL NAME: JOSEPH BRYANT

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 3-5-1887

8. AGE: Years	Months	Days	If less than one day
60	3	26	hrs. min.

9. Birthplace: Green Pond, South Carolina
(Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business:

FATHER
12. Name: Frank Bryant
13. Birthplace: Green Pond, South Carolina

MOTHER
14. Maiden name: Sallie Chaplin
15. Birthplace: Green Pond, South Carolina

16. Informant: Clinical Records, Vets.Adm. Hosp.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
Cemetery or crematory: Private
Location:

18. Funeral director: Charles R. Law
Address: 802 Madison Ave., Balto., Md.

19. 7/3 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 1 19 47 at 7:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 3 19 47 to July 1 19 47 and that I last saw him alive on July 1 19 47

	DURATION
Immediate cause of death: CARCINOMA OF STOMACH WITH METASTASIS	7 mos. plus
Due to:	
Due to:	
Other conditions: Secondary Anemia	3 mos. plus

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: E. V. Dustin M. D. or other
Address: V.A. Fort Howard, Md. Date signed: 7-2-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06465 93d

Reg. Dist. No. 42

1. PLACE OF DEATH

County Baltimore

City or town Relay (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred: 5169 Sundry Lane

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County Baltimore

City or town Relay (If outside city or town limits, write RURAL and give nearest town)

Street No. 5169 Sundry Lane (If rural, give LOCATION)

2.(a) If veteran, name war none

3.(a) FULL NAME Catherine Mary Byrne

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 20, 1854

8. AGE: Years 92 | Months 9 | Days 2 | If less than one day ... hrs. ... min.

9. Birthplace Relay Md (Town, county, and state)

10. Usual occupation Housework

11. Industry or business Retired (Families)

FATHER 12. Name Andrew Byrne

FATHER 13. Birthplace Ireland

MOTHER 14. Maiden name Catherine Hughes

MOTHER 15. Birthplace Ireland

16. Informant Mrs. Adelaide M. Barrett (Relative) Address 5169 Sundry Lane, Relay, Md

17. Burial (Burial, cremation, or removal) Date thereof 7/25/47 (month) (day) (year)

Cemetery or crematory St Augustines Cem

Location Elkridge, Md

18. Funeral director John J. Kenney & Son

Address 401-03 S. Eden St

19. 7-28-47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 1947 at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1946 to July 22 1947 and that I last saw h[illegible] alive on July 22 1947

Immediate cause of death	DURATION
(a) Myocardial	6 mo.
Due to (b) Hypertension	10 yrs
Due to (c) Senility	18 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE B. B. Brumbaugh M.D. or other

Address 600 Main Elkridge 27 Md Date signed 7/24/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05752

164C

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:
County: Baltimore
City or town: Turner's Station
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? 5 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: —
City or town: Turners Station
(If outside city or town limits, write RURAL and give nearest town)
Street No. 132 Cross Beach Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: John Cabell, John

3.(b) Social Security Number: 214-28-6598.

4. Sex: M W Be
5. Color or race
6.(a) Single, married, widowed, or divorced: Married.
6.(b) Name of husband or wife: Irene Cabell
6.(c) If alive, give age: 38 years
7. Birth date of deceased (mo., day, yr.): Feb 19-1907.

8. AGE: Years: 40 Months: 4/0 Days: If less than one day: hrs. min.

9. Birthplace: Madison Heights Va. (Town, county, and state)
10. Usual occupation: Steel worker.
11. Industry or business: Sparrows Point
12. FATHER Name: Scott Cabell
13. FATHER Birthplace: Madison Heights Va.
14. MOTHER Maiden name: Mary Essex
15. MOTHER Birthplace: Nelson Co. Va.
16. Informant: Irene Cabell
Address: 2118 N. Howard St.
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 16-47. (month) (day) (year)
Cemetery or crematory: Bolding Hill Cem.
Location: Madison Heights Va.
18. Funeral director: Elroy O Wilson
Address: 1000 Brantly Ave.
19. 7/14 1947 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 12th 1947 at 6:00 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19... and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death: GUN SHOT WOUND	
Due to: THRU floor of	
Due to: MOUTH —	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: SUICIDE Date of 7-12-47
Where did injury occur? TURNER'S STA - BALTO Co (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) PUBLIC PLACE
Means of injury SHOT SELF PISTOL Injured at work?

23. SIGNATURE: [illegible] M.D.
Address: [illegible] Date signed 7/12/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct one is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

166

CERTIFICATE OF DEATH

05753

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Baltimore

City or town: Turner's Station

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County:

City or town: Turners Station

(If outside city or town limits, write RURAL and give nearest town)

Street No. 310 Grove Court

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME MARY CABELL

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	Bl.	Marr'd.

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1910

8. AGE: Years	Months	Days	If less than one day
37			..... hrs. ..... min.

9. Birthplace Vaughan N. C. (Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

FATHER — 12. Name Andrew Brinkley

13. Birthplace Vaughan N. C.

MOTHER — 14. Maiden name Ada E Brown

15. Birthplace Vaughan N. C

16. Informant William Brinkley

Address 1695 E. Jefferson St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 16-47 (month) (day) (year)

Cemetery or crematory Ashley Grove cem.

Location Vaughan N. C.

18. Funeral director Elvin O. Wilson

Address 1000 Brantly Ave.

19. 7/14. 1947 [illegible] Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12th 1947, at 4:15 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Gun Shot Wounds Thru Left & Rigm Chest	—
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation None Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Homicide Date of 7-12-47

Where did injury occur? Turners Sta. (City or town) Balto (County) Md. (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Shot by husband Injured at work? No

23. SIGNATURE [illegible] M.D. or other

Address [illegible] Date signed 7/14/1947

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

61

05754

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Baltimore

City or town Colgate-Berkshire Apts.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.

City or town Colgate Berkshire

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1018 Edmondson Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Julia Callahan

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	

6.(b) Name of husband or wife John Callahan

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 7- 1891

8. AGE: Years	Months	Days	If less than one day
56	5	20	..... hrs. ..... min.

9. Birthplace Va (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business at Home

FATHER 12. Name Joseph Twigg

13. Birthplace Va.

MOTHER 14. Maiden name Unknown

15. Birthplace Va

16. Informant Mrs. Ann R. Twigg

Address Balto Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/29/47 (month) (day) (year)

Cemetery or crematory Holy Cross

Location Gov. Ritchie Highway

18. Funeral director John F. Connelly

Address 418 Eastern Ave

19. 7/28 1947 John F. Connelly Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-27-47 19..... at 2:00 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	
Due to A-S-C-V. Disease	
Due to	
Other conditions Diabetis Mellatus	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) None (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. B. Davis M.D.

Dep. Med. Examr, Balto M. D., or other

Address Balto 3, Md. Date signed 7-27-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1246 BC

05757

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 33 days

Hospital, institution, or street address where death occurred:
Veterans Administration Hospital

How long in hospital or institution? 33 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 126 Siegwart Lane
(If rural, give LOCATION)

2.(a) If veteran, name war: WW II

3. (a) FULL NAME: HARRY E. CHAIFFRE

3. (b) Social Security Number: 216-16-1197

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: Single

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 20, 1924

8. AGE: Years	Months	Days	If less than one day
23	1	2	hrs. min.

9. Birthplace: Pittsfield, Mass.
(Town, county, and state)

10. Usual occupation: Draftsman

11. Industry or business:

FATHER
12. Name: Armond J. Chaiffre
13. Birthplace: New York

MOTHER
14. Maiden name: Linda Conklin
15. Birthplace: Hancock, Mass.

16. Informant: Clinical Records, Vets. Adm. Hospl.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/25/47 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery

Location: Baltimore, Maryland

18. Funeral director: Howard Blight Funeral Home
Howard N. Blight Jr.

Address: 4914 Belair Rd., Baltimore, Md.

19. July 24 19 47 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 22 1947, at 6:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 1947, to July 22 1947 and that I last saw him alive on July 22 1947

Immediate cause of death	DURATION
Portal Cirrhosis of liver	2 Mos plus
Due to: Unknown	
Due to:	
Other conditions: Ascites Due to Above.	

(Include pregnancy within 3 months of death)

Major findings of operations: Biopsy of Liver Date of op. 7-22-47

Autopsy results: Substantiated Above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert M. Cullison M. D. or other

R. M. CULLISON, M.D. CLIN. DIRECTOR

Address: V.A.H. FORT HOWARD, MD. Date signed 7-22-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

06466 P.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville 28, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 yrs., 3 mos., 13 das.
Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 18 yrs., 3 mos., 13 das.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME
Harry G. Chronister

3. (b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	w	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 14, 1880 ?

8. AGE: Years	Months	Days	If less than one day
67	2	9	hrs. min.

9. Birthplace: Pennsylvania
(Town, county, and state)
10. Usual occupation: Piano business
11. Industry or business: Piano business

FATHER
12. Name: ? Tempest K. Chronister
13. Birthplace: ? Penna

MOTHER
14. Maiden name: ? Lucy A. Hull
15. Birthplace: ? Penna

16. Informant: Hospital Records
Address: Catonsville 28, Maryland

17. (Burial, cremation, or removal. Which?) Burial Date thereof July 25-1947 (month) (day) (year)
Cemetery or crematory: Baltimore
Location: Bath No. 3
18. Funeral director: Putnam & Gore
Address: 2234 N. Charles St.

19. July 24 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 23, 1947, at 9:45 a. m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 10, 1929 to July 23, 1947 and that I last saw him alive on July 23, 1947

Immediate cause of death	DURATION
General paresis	indef
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D.
M. D. or other
Address: Catonsville 28, Md. Date signed: 7/23/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

05755

P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13 (a)

CERTIFICATE OF DEATH

Reg. Diat. No. 44

1. PLACE OF DEATH:

County Balto

City or town Colgate (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md County Balto

City or town Colgate (If outside city or town limits, write RURAL and give nearest town)

Street No. 513 S 48th St (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Ralph W. Clarke

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Christina Clarke

6.(c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) July 20, 1890

8. AGE: Years 56 Months 11 Days If less than one day ..... hrs. ..... min.

9. Birthplace Salt Lake City (Town, county, and state)

10. Usual occupation

11. Industry or business Machinist

FATHER 12. Name Don't Know

13. Birthplace "

MOTHER 14. Maiden name Don't Know

15. Birthplace "

16. Informant Christina Clarke

Address 513 S 48th St

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 19-1947 (month) (day) (year)

Cemetery or crematory Oak Lawn

Location City

18. Funeral director Ulrich Funeral Home

Address 2008 Orleans St

19. 7/18/47 (Date rec'd by registrar) A.W. Kedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 1947 at 9:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1st 1947 to July 15- 1947 and that I last saw him alive on July 15- 1947

Immediate cause of death	DURATION
Arteria-Sclerotic Cardio-	
Due to Vascular Renal Disease	4 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation None Date of op.

Autopsy results No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James F. White M.D. M. D. or other

Address 1607 Eutaw Pl Balto, 24, Md Date signed 7/16/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46 f

05756

P.

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:
County Baltimore
City or town Dundalk
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? .....
Hospital, Institution, or street address where death occurred:
.....
How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto
City or town Dundalk
(If outside city or town limits, write RURAL and give nearest town)
Street No. 207 Cleveland Ave
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3.(a) FULL NAME Richard L. Coleman — **3.(b) Social Security Number**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mary Coleman
6.(c) If alive, give age 36 years
7. Birth date of deceased (mo., day, yr.) August 10th, 1905

8. AGE: Years 41 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Cuba (Town, county, and state)
10. Usual occupation Bethlehem Steel
11. Industry or business
FATHER 12. Name Richard Coleman
13. Birthplace S. Carolina
MOTHER 14. Maiden name Julia Martinez
15. Birthplace Cuba
16. Informant Mary Coleman
Address 207 Cleveland Ave
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 2. 1947 (month) (day) (year)
Cemetery or crematory Oak Lawn
Location City
18. Funeral director Ulrich Funeral Home
Address 2008 Orleans St
19. 7-31 19 47 (Date rec'd by registrar) A. W. Ulrich (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30th 1947 at 12 30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 7 19 47 to July 30 19 47 and that I last saw h.. alive on July 29 19 47

	DURATION
Immediate cause of death Adenoma of Liver	8 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? None (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE M B Davis M.D. M. D. or other
Address Dundalk - R.R. No 7 Date signed 7-31-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Med. Ex. Dr Kieffer 2470 Washington Blvd Bal 018500 - 1010 Leadenhall Apt 105

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

930.

05758

CERTIFICATE OF DEATH

Reg. Dist. No. 42

M

1. PLACE OF DEATH:

County Balto

City or town Arbutus

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

~~Hospital, institution, or~~ street address, where death occurred:

1237 Vogt Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Balto

~~City or~~ town Arbutus

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1237 Vogt Ave

(If rural give LOCATION)

2.(a) If veteran, name war W.W. #1 and #2

3.(a) FULL NAME Walter H. Costella

3.(b) Social Security Number 181-09-3273

4. Sex	5. Color or race	6. ~~(a)~~ Single, married, ~~widowed, or divorced~~
Male	White	Married

6.(b) Name of ~~husband or~~ wife Mae Costella

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb 18th 1900

8. AGE: Years	Months	Days	If less than one day
47	4	26	..... hrs. ..... min.

9. Birthplace Phila Pa.

(Town, county, and state)

10. Usual occupation Shoe Salesman

11. Industry or business May Co.

FATHER 12. Name Costella

13. Birthplace Pa.

MOTHER 14. Maiden name

15. Birthplace Pa.

16. Informant Mrs. Mae Costella

Address 1237 Vogt Ave - Arbutus

17. Burial Date thereof 7/18/47

(Burial, ~~cremation, or removal~~. Which?) (month) (day) (year)

Cemetery ~~or crematory~~ U.S. National

Location Balto. Md.

18. Funeral director William Cook Inc.

Address 127 St. Paul St.

19. July 5 47 Geo Kieffer

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14th 1947 at 7:45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h ..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary occlusion	
Due to	
Cardio Vascular disease	
Other conditions	
sudden death	
Injury	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Geo Kieffer Asst Med Examiner Balto

M. D. or other

Address 1010 Leadenhall Date signed 7-15-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
JUL 17 1947
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d 05759 Reg. Dist. No. 1.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Balto.
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Catonsville Convalescent Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto
City or town: Sparrows Point
(If outside city or town limits, write RURAL and give nearest town)
Street No.: West Side of Shore Rd. near Dogwood
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: William Cotterman

3.(b) Social Security Number: 213-09-3182

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Viola Cotterman
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb 8th 1878

8. AGE: Years	Months	Days	If less than one day
69	6	19	..... hrs. ..... min.

9. Birthplace: Ohio
(Town, county, and state)
10. Usual occupation: Heater in Warehouse
11. Industry or business: Bethlehem Steel Co. Sparrows Point

FATHER
12. Name: Unknown Cotterman
13. Birthplace: "

MOTHER
14. Maiden name: "
15. Birthplace: "

16. Informant: L. D. Cunningham
Address: 319 E. St. Sparrows Point Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/6/47 (month) (day) (year)
Cemetery or crematory: Maryland Park
Location: Parkville Md.

18. Funeral director: William Cook Inc.
Address: 1217 St. Paul St.

19. 7/5 (Date rec'd by registrar) 1947 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 27 1947, at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 7 1947, to July 27 1947
and that I last saw h.. alive on April 7 July 27 1947

	DURATION
Immediate cause of death: Cerebral hemorrhage	unctn
Due to: Hypertensive cardiovascular disease	?
Due to:	
Other conditions: Cerebral hemorrhage	1946

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Jos. C. Kortman, Jr. M. D. or other
Address: Ellicott City Md. Date signed 7/27/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

66467

61

Reg. Dist. No. 43

1. PLACE OF DEATH:
County Baltimore
City or town Overlea
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 yrs
Hospital, institution, or street address where death occurred:
103 E. Overlea ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Overlea
(If outside city or town limits, write RURAL and give nearest town)
Street No. 103 E. Overlea ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: AGNES M. COUNTESS

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

6.(b) Name of husband or wife: J. Edgar Countess, Sr.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 30, 1873

8. AGE: Years	Months	Days	If less than one day
73	6	22	..... hrs. ..... min.

9. Birthplace: Howard Co., Md.
(Town, county, and state)

10. Usual occupation: At home

11. Industry or business

FATHER
12. Name: James D. Gallagher
13. Birthplace: Howard Co. Md.

MOTHER
14. Maiden name: Caroline Baker
15. Birthplace: Howard Co., Md.

16. Informant: J. Edgar Countess, Jr.
Address: 103 E. Overlea ave.

17. Burial — Date thereof 7/25/47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: New Cathedral Cemetery
Location: Frederick road

18. Funeral director: Chas G. Evans & Son Inc
Address: 118 W. Mt. Royal Ave.

19. July 24 19 47 — A. W. Heusch
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 22 19 47, at 8:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 8 19 47, to July 22 19 47
and that I last saw her alive on July 21 19 47

Immediate cause of death	DURATION
Cardiac Failure	1 Day
Due to Cardio-Vascular Hypertensive disease	10 years?
Due to Arteriosclerosis	10 years?
Other conditions Deabetes	10 years.

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Michael J. Dausch M.D.
M. D. or other
Address 1 W. Overlea Ave Date signed 7-23-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Dr. Michael Dausch
1 W. Overlea ave.

STATE OF MARYLAND—CERTIFICATE OF DEATH

121 05760

1. PLACE OF DEATH

County Baltimore Registration Dist. No.

Village or City Timmonium Md. No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME William Henry Cox If U. S. Veteran, specify WAR

(a) Residence: No. Timmonium Md St., Ward. If nonresident give city or town and State

(Usual place of abode)

S.S# 212-22-9119

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	White	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Neomi G. Cox

6. DATE OF BIRTH (month, day, and year) Oct 4, 1876

7. AGE Yeers	Months	Days	If LESS than 1 day, hrs. or min.
70	9	1	

OCCUPATION

8. Trade, profession, or particuler kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Filer

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Black & Decker

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Cockeysville (State or country) Maryland

FATHER

13. NAME William Henry Cox

14. BIRTHPLACE (city or town) Unknown (State or country)

MOTHER

15. MAIDEN NAME Katherine Sanders

16. BIRTHPLACE (city or town) Unknown (State or country)

17. INFORMANT Neomi G. Cox (Address) Timmonium Md.

18. BURIAL, CREMATION, OR REMOVAL Place Fairview M.E. Cemetery Date July 8, 1947 Govans Md.

19. UNDERTAKER Ellsworth Armacost (Address) 3911 Liberty Heights Ave

20. FILED July 7, 1947 A. D. Hedrick Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH July (Month) 5 (Day), 1947 (Year)

22. I HEREBY CERTIFY, That I attended deceased from July 4 1947, to July 5, 1947

I last saw him alive on July 4, 1947; death is said to heve occurred on the date steted ebove, at 11.25 a.m.

The PRINCIPAL CAUSE OF DEATH end related causes of Importance were es follows:

	Date of onset
Peritonitis	
Ruptured appendicitis	5/23/47
Gall bladder	
Chole cystitis Smith	
Other Contributory Causes of Importance: drainage	6/8/47

Name of operation Appendectomy Date of 5/23/47

Cholecystotomy 6/8/47

What test confirmed diagnosis? Wes there an autopsy?

23. If deeth wes due to external causes (VIOLENCE) fill in elso the following:

Accident, suicide, or homicide? Date of Injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether Injury occurred in INDUSTRY, In HOME, or in PUBLIC PLACE.

Manner of Injury

Nature of Injury

24. Was disease or injury in eny way related to occupation of deceased?

If so, specify

(Signed) Bennett A. Green M. D.

(Address) Ruthervville, Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting V. S. No. 1.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or **at home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel**, etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill**, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer**, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist**, etc. Distinguish carefully between **retail merchants** and **wholesale merchants**. A person who sells goods should be called a **salesman** and not a **clerk**.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The **principal cause of death** and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The **principal cause of death** and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

05761

CERTIFICATE OF DEATH

Reg. Dist. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Delta
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Hollow Road, Delta.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Delta
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Hollow Road
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Asbury Middleton Cross

3.(b) Social Security Number: 213-09-6360

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife: Jannie Catherine Cross
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 26, 1890

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
56	9	6		

9. Birthplace: Howard Co. Md.
(Town, county, and state)
10. Usual occupation: Weaver
11. Industry or business: Dairy Milk, Delta.
FATHER 12. Name: Nelson Cross
13. Birthplace: Unknown
MOTHER 14. Maiden name: Emma Gordon
15. Birthplace: Howard Co. Md.
16. Informant: Mrs Jannie C. Cross
Address: Delta, Baltimore Co. Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 5, 1947 (month) (day) (year)
Cemetery or crematory: St. John's Cemetery
Location: Ellicott City, Md.
18. Funeral director: Easton Sons
Address: Ellicott City Md.
19. 7-3 1947 (Date rec'd by registrar) Harry D. Shipley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2 July 1947 at 5 30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 28 Jan. 1947, to 2 July 1947
and that I last saw him alive on 28 Jan. 1947

Immediate cause of death	DURATION
Coronary Thrombosis	immediate
Due to: Arteriosclerotic Cardiac Disease & Cardiac Insufficiency	3 years.
Due to: Hypertensive Cardio Vascular Disease	? years.
Other conditions: None.	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: William F. Jarrawey M. D. or other
Address: Ellicott City, Md. Date signed: 2 July 47.

RECEIVED
JUL 12 1947
BUREAU OF S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 38 — 05782

1. PLACE OF DEATH:

County: Baltimore

City or town: Towson 4, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since February 7, 1947

Hospital, Institution, or street address where death occurred: Eudowood Sanatorium, Towson 4, Md.

How long in hospital or institution? Since February 7, 1947

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Baltimore City

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 1303 Hillman (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mary Barbara Davey

3.(b) Social Security Number: 216-16-5410

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 17, 923

8. AGE: Years: 23 | Months: 11 | Days: | If less than one day: hrs. min.

9. Birthplace: Baltimore Md (Town, county, and state)

10. Usual occupation: Office Clerk

11. Industry or business:

FATHER — 12. Name: Joseph Davey

13. Birthplace: Baltimore Md

MOTHER — 14. Maiden name: Helen Brown

15. Birthplace: Wilmington, Del

18. Informant: Personal history - Hospital Records

Address: Eudowood Sanatorium, Towson 4, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 25, 1947 (month) (day) (year)

Cemetery or crematory: Holy Redeemer

Location: Baltimore

18. Funeral director: Rita Weedfeld

Address: 900 East Biddle St

19. July 23 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 21 1947, at 10:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 7 1947 to July 21 1947 and that I last saw h alive on July 21 1947

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	Since Nov. 1946
Due to: Tuberculous infection	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. A. Bridges M. D. or other

Address: Towson 4, Maryland Date signed: 7-21-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

05763

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:

County: Baltimore

City or town: Middleborough

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:

.....

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Middleborough

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Fred Avon Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME: Anna M. Dedio

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Charles F. Dedio

6.(c) If alive, give age.....years

7. Birth date of deceased (mo., day, yr.): Sept. 27-1866

8. AGE: Years	Months	Days	If less than one day
80	9	16	.....hrs. .....min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER — 12. Name: Wm. Goldbeck

FATHER — 13. Birthplace: Germany

MOTHER — 14. Maiden name: Elizabeth Jophorn

MOTHER — 15. Birthplace: Germany

16. Informant: Francis P. Gomeringer

Address: Fred Avon Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 15-47 (month) (day) (year)

Cemetery or crematory: Oak Lawn Cemetery

Location: Eastern Ave.

18. Funeral director: John L. Miller

Address: 2334 Jefferson St.

19. July 14 19 47 A. au Fedrick Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 12 19 47 at 3:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 9 19 47, to July 12 19 47 and that I last saw her alive on July 12 19 47

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 days.
Due to Arteris-Sclerotic Cardio-	
Due to Vascular Lesions	4 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: no

Date of op.....

Autopsy results: no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: James F. White M.D. M. D. or other

Address: 4601 Eastern Ave, Baltimore 24, Md. Date signed 7/14/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

05764

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore County
City or town: Rockwell Ave. Della
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 2209 Rockwell ave
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto
City or town: Della Catonsville Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Rockwell ave
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: RUFUS B. DE LAWTER

3. (b) Social Security Number

4. Sex: male
5. Color or race: white
6. (a) Single, married, widowed, or divorced: widowed
6 (b) Name of husband or wife: SARAH DE LAWTER (NEE) DEMEREST
6 (c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): Oct. 25, 1868
8. AGE: Years 78 Months 8 Days If less than one day ____ hrs. ____ min
9. Birthplace: Frederick Co. Maryland
(Town, county, and state)
10. Usual occupation: farmer
11. Industry or business
FATHER 12. Name: GEORGE W DELAWTER
13. Birthplace: Maryland
MOTHER 14. Maiden name: ISABEL BROWN
15. Birthplace: Maryland
16. Informant: ERNEST DELAWTER
Address: Highfield Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 31, 1947 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: Baltimore, Md.
18. Funeral director: Edward S. MacNabb
Address: 301 Frederick Ave Catonsville
19. 7-31 1947 (Date rec'd by registrar) Harry W. Miller Registrar Deputy

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 28 1947, at 9 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw h__ alive on ____ 19__

Immediate cause of death	DURATION
Acute cardiac failure	
Due to	
Due to Cardio vascular disease	

Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ____ Injured at work?

23. SIGNATURE: Geo S M Kieffer Dep. Med. Exam. of Balt. M. D., or other
Address: 1010 Leeds Ave Date signed: 7-28-47

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05765 P

93d

Reg. Dist. No. 38

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Parkville
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
8 Linganore Avenue
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Parkville
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 8 Linganore Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Walter Amos Doxen

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Helen C. Doxen
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 7, 1886

8. AGE: Years	Months	Days	If less than one day
60	9	29	..... hrs. ..... min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual occupation B. & O. R.R.
11. Industry or business
FATHER 12. Name John Thomas Doxen
13. Birthplace Md.
MOTHER 14. Maiden name Georgianna Kelley
15. Birthplace Md.
16. Informant Mrs. Helen C. Doxen
Address 8 Linganore Avenue
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/9/47 (month) (day) (year)
Cemetery or crematory Mt Zion
Location Belair, Md.
18. Funeral director Leonard J. Ruck
Address 5305 Harford Road, 14
19. July 7 1947 A. W. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6th, 1947, at 6 00 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1947, to July 6 1947
and that I last saw h... alive on July 5, 1947

	DURATION
Immediate cause of death: acute pulmonary edema	1 day
Due to: arteriosclerotic cardio-vascular disease.	1 yr.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Harold A. Groth, M.D.
M. D. or other
Address 8100 Harford Rd. Date signed 7/6/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

55-e

CERTIFICATE OF DEATH

Reg. Dist. No. 05366 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 Days
Hospital, Institution, or street address where death occurred:
House in the Pines 16 Fusting Ave.
How long in hospital or institution? 6 Days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residance of mother)
State: Maryland County:
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. 603 Ashburton Street (If rural, give LOCATION)
2.(a) If veteran, name war: NO

3.(a) FULL NAME: John Carl Dwyer

3.(b) Social Security Number: 705-07-9435

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Nancy Dwyer
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): OCT. 1, 1873

8. AGE: Years	Months	Days	If less than one day
73	9	14	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: B&O Railroad
FATHER 12. Name: John Dwyer
FATHER 13. Birthplace: MD.
MOTHER 14. Maiden name: UNKNOWN
MOTHER 15. Birthplace: "
16. Informant: Russell R. Dwyer
Address: Long Point AACo Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/18/47 (month) (day) (year)
Cemetery or crematory: Moreland Memorial
Location: Parkville, Md.
18. Funeral director: George W. Little
Address: 2700 Edmondson Ave.
19. 7/17 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 15, 1947 19 11/5 hr. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 1947 to July 15 1947 and that I last saw h. him alive on July 13 1947

Immediate cause of death	DURATION
Myocardial degeneration and insufficiency. Arteio sclerotic type heart disease	6 months
Due to Generalized arteio sclerosis.	
Due to Lung neoplasm (probable, malignant) in abdominal cavity.	4 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. Michel MD M. D. or other
Address: 290 Edmondson Ave Date signed July 16 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

05767

CERTIFICATE OF DEATH

Reg. Dist. No. 32

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Baltimore
City or town: Pikesville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
112 Church Lane Pikesville Md
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County:
City or town: Church Lane Pikesville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 112 Church Lane
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Jacob Mordecai Ephraim

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Rachel
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1887

8. AGE: Years	Months	Days	If less than one day
60			hrs. min.

9. Birthplace: Russia
(Town, county, and state)
10. Usual occupation: Retired Merchant
11. Industry or business: Store

FATHER
12. Name: Dr Louis H Ephraim
13. Birthplace: Russia

MOTHER
14. Maiden name: Esther ?
15. Birthplace: Russia

16. Informant: Mendel Ephraim
Address: 112 Church Lane Pikesville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 6, 1947 (month) (day) (year)
Cemetery or crematory: Hebrew Rosedale Cem
Location: Hamilton Ave

18. Funeral director: Sol Levinson & Bros
Address: 1124-1126 W North Ave

19. July 5 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 4 1947, at 3.45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 10 1934 to 4 July 1947 and that I last saw him alive on 2 July 1947

Immediate cause of death	DURATION
Coronary thrombosis (Myocardial infarct)	1 day.
Due to: Coronary arteriosclerosis	
Due to: Generalized arteriosclerosis; Arterial hypertension	13 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Louis P. Hamburger M. D. or other
Address: 1207 Eutaw Place Date signed: July 5 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6494 P

186a

BC

Reg. Dist. No. 230

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville 28, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 mo., 26 das.
Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 1 mo., 26 das.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1417 Hollins Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME
a.
Millicent Erler

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
f	w	widowed

6.(b) Name of husband or wife: George R. Erler
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 30, 1867

8. AGE:

Years	Months	Days	If less than one day
80	2	24	hrs. min.

9. Birthplace: Scranton, Pennsylvania
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Domestic

FATHER
12. Name: Richard Woodring
13. Birthplace: Ohio

MOTHER
14. Maiden name: --------
15. Birthplace: --------

16. Informant: Hospital Records
Address: Catonsville 28, Maryland

Lorraine Pk. Date thereof 7/28/47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crema: Lorraine Pk. Mausoleum
Location: Woodlawn, Md.
18. Funeral director: Harry H. Tritle
Address: 410 E Edmondson Ave

19. 7/28 19 47 Alw Edwards Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 24, 19 47 at 4:07 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Acute Myocardial Failure	
Pulmonary edema	
Due to: Generalized Arteriosclerosis	
Due to:	
Other conditions: Fracture Left Hip accident	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results: Ao abn
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide? Accident Date of injury July 10 47 4:35 PM
Where did injury occur? Catonsville (City or town) Baltimore (County) (State)
Injured at home, farm, industry, public place (where?): Hospital
Means of injury: slipped and fell on floor Injured at work? no
Dead on Arrival

23. SIGNATURE: Geo. J. McKieffer Geo. J. McKieffer M.D.
M. D. or other
Address: 1010 Leadenhall Date signed: 7-25-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

92 b

05768

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
62 Winters Lane
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 62 Winters Lane
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: ELLA H. FAUNTAIN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widow

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 1, 1865

8. AGE: Years	Months	Days	If less than one day
82	6		hrs. min.

9. Birthplace: Piney Grove, Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Charles Dett
13. Birthplace: Md

MOTHER
14. Maiden name: Sarah Johnson
15. Birthplace: Md

16. Informant: Miss Maxine Briscoe
Address: 62 Winters Lane

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-11-47 (month) (day) (year)
Cemetery or crematory: Mt. Auburn Cem
Location: Baltimore, Md.

18. Funeral director: Mrs. Frances A. Hemsley
Address: 578 W. Biddle St.

19. July 10 1947 (Date rec'd by registrar) a. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 8 1947 at 2:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-10-46 19.. to 7-8-47 19.. and that I last saw h.. alive on 7-8-47 19..

Immediate cause of death	DURATION
Mitral Insufficiency	?
Due to: Arteriosclerosis	?
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: / Date of op. /
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. J. Maloney M.D. M. D. or other
Address: 57 Winters Lane Date signed: 7/8/47
Balto-28 Md

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

920 06468

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:
County: BALTO
City or town: ENGLISH COUNCIL
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? .....
Hospital, Institution, or street address where death occurred:
.....
How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MD. County: BALTO
City or town: ENGLISH COUNCIL
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4435 WALNUT AVE
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3.(a) FULL NAME: LEO. J. FEEHELY.

3.(b) Social Security Number: 215-09-5906

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED.

6.(b) Name of husband or wife: GRACE L. FEEHELY.
6.(c) If alive, give age: 35 years

7. Birth date of deceased (mo., day, yr.): OCT. 12-1899.

8. AGE: Years	Months	Days	If less than one day
47	9	10	.....hrs. .....min.

9. Birthplace: BALTO MD (Town, county, and state)
10. Usual occupation: ELECTRICIAN HELPER
11. Industry or business: DAVIDSON CHEMICAL CO.
FATHER 12. Name: MICHAEL FEEHELY.
13. Birthplace: BALTO MD
MOTHER 14. Maiden name: HATTIE WOOTEN.
15. Birthplace: BALTO MD
16. Informant: GRACE L FEEHELY.
Address: 4435 WALNUT AVE
17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: JULY 25-47 (month) (day) (year)
Cemetery or crematory: HOLY CROSS.
Location: B. A. CO.
18. Funeral director: Bernard C. Hasle
Address: 131 E West St
19. July 23 1947 (Date rec'd by registrar) C. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JULY. 22 1947 at 8 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Jan. 1 1947, to July 22 1947
and that I last saw h... alive on July 22 1947
Immediate cause of death: Coronary Thrombosis — DURATION: 1 minute
Due to: Hypertension — DURATION: .....
Due to: Aortic Stenosis — DURATION: 2 yrs.
Other conditions: .....
(Include pregnancy within 3 months of death)
Major findings of operations: .....
Date of op. .....
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: R. E. L. Compton M. D. or other
Address: 1644 Hanover St (30) Date signed: 7/22/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I)

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

C6469 ?

Reg. Diat. No. .....

1. PLACE OF DEATH:

County Baltimore

City or town Essex

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? -

Hospital, Institution, or street address where death occurred:

503 Franklin Avenue

How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore

City or town Essex

(If outside city or town limits, write RURAL and give nearest town)

Street No. 503 Franklin Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME Charles E. Foulke

3.(b) Social Security Number 215 22 6871

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Eva

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) January 14, 1893

8. AGE: Years	Months	Days	If less than one day
54			..... hrs. ..... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business Enterprise

FATHER

12. Name Frank F. Foulke

13. Birthplace Baltimore County

MOTHER

14. Maiden name Sarah Ford

15. Birthplace Baltimore County

16. Informant Eva Foulke

Address 503 Franklin Ave., Essex

17. Burial (Burial, cremation, or removal. Which?) Date thereof August 1st (month) (day) (year)

Cemetery or crematory Cemetery

Location Oak Lawn

18. Funeral director Wm. Cook, Inc.

Address 1217 St. Paul Street

19. 7-31 19 47 C. C. Hedrick Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29, 19 47 at 9:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sat 15 19 45, to July 29 19 47

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Myocardial infarction	6 hrs
Due to Coronary thrombosis	6 hrs
Due to Arteriosclerosis of coronary arteries	2 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE R. A. Fuller M.D.

M. D. or other

Address Ridge Rd Balt-6 md Date signed 7/30/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05769

CERTIFICATE OF DEATH

Reg. Diat. No. 31

1. PLACE OF DEATH:

County: Baltimore

City or town: Rural - Reisterstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 mo.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Rural - Reisterstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mary Helen Thomas Gaither

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband ~~or wife~~: Tobias Gaither

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): May 22, 1909

8. AGE: Years: 38 | Months: 1 | Days: 17 | If less than one day: hrs. min.

9. Birthplace: Carroll Co. Maryland (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER — 12. Name: Alpheus Thomas

13. Birthplace: Md

MOTHER — 14. Maiden name: Bessie Dorsey

15. Birthplace: Md.

16. Informant: Alpheus Thomas

Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-12-47 (month) (day) (year)

Cemetery or crematory: White Rock

Location: Bennett, Carroll Co. Md.

18. Funeral director: E. M. Waltz

Address: Winfield, Md.

19. 7/9/1947 (Date rec'd by registrar) Wm. E. Martin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 9 19 47 at 6:20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-3-'47 19 to 7-3-'47 19

and that I last saw her alive on not seen alive 19

Immediate cause of death	DURATION
Pulmonary Hemorrhage	30 min.
Due to: Pulmonary Tbc.	4 yrs.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: NONE Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? NONE (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Dr D.D. Caples Med. Exam. M. D. or other

Address: Reisterstown, Md. Date signed 7-9-'47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15


RECEIVED
AUG 7 1947
BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

05770

CERTIFICATE OF DEATH

Reg. Dist. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Records Knoll
How long in hospital or institution? Daughter of Cecilian

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md County: Balt
City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)
Street No.: Maiden Choice Lane (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mary B Gallagher
3.(b) Social Security Number:

4. Sex: F
5. Color or race: W
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Not Known
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Feb 3 1861
8. AGE: Years 86, Months 5, Days 18; If less than one day ... hrs. ... min.
9. Birthplace (Town, county, and state): Not Known
10. Usual occupation: None
11. Industry or business
FATHER
12. Name: Not Known
13. Birthplace: " "
MOTHER
14. Maiden name: " "
15. Birthplace: " "
16. Informant: Records Knoll Records
Address: Daughter Cecilian
17. Burial (Burial, cremation, or removal, Which?) Date thereof (month) (day) (year)
Cemetery or crematory: Cathedral Cem
Location: Baltimore Md
18. Funeral director: Geo. A Thaley
Address: Catonsville
19. 7-22 1947 Harry H. Miller, Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 21 1947, at 6 a M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Acute cardiac failure	
Due to: Cardio vascular disease	
Due to	
Other conditions: sudden death Injury (Include pregnancy within 3 months of death)	

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: Geo J McKieffer, Deputy Med. Exam. Balto Co., M. D. or other
Address: 1010 Leeds Ave Date signed: 7-22-47

M I VS A15

RECEIVED
JUL 23 1947
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

CERTIFICATE OF DEATH

05771

Reg. Dist. No. 41

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH

County: Balto.

City or town: Dundalk

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Dundalk

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1908 Crafton Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mary C. Glass

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 12 - 1867

8. AGE:

Years	Months	Days	If less than one day
79	7	26	hrs. min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

FATHER

12. Name: Not Known

13. Birthplace: Not Known

MOTHER

14. Maiden name: Not Known

15. Birthplace: Not Known

16. Informant: Charles W. Higgs

Address: 1908 Crafton Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 10-47 (mo.) (day) (year)

Cemetery or crematory: Mt. Carmel Cem.

Location: E Donnell St.

18. Funeral director: John L. Milby

Address: 2334 Jefferson St.

19. 7/8/47 19.. L McCarmine (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 7 1947 at 1 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1947 to July 1947

and that I last saw her alive on July 7, 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to: Hemiplegia	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: L McCarmine M.D. M. D. or other

Address: Dundalk 22 Md. Date signed: 7/8/47

RECEIVED
JUL 12 1947
BUREAU OF S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 138

CERTIFICATE OF DEATH

05772

Reg. Dist. No. .....

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 days

Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Ft. Howard, Md.

How long in hospital or institution? 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2926 Elliott St.
(If rural, give LOCATION)

2.(a) If veteran, name war: WW II

3. (a) FULL NAME: GRABOWSKI, William J.

3. (b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: Single

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 8/7/04

8. AGE: Years	Months	Days	If less than one day
42	10	222	..... hrs. ..... min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: .....

11. Industry or business: .....

FATHER
12. Name: William Grabowski
13. Birthplace: ~~Unknown~~ Poland

MOTHER
14. Maiden name: Julia ? Stopczynski
15. Birthplace: ~~Unknown~~ Poland

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Fort Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Balt. National Date thereof July 7, 1947 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery

Location: Baltimore, Md.

18. Funeral director: John M. Weber

Address: 401 S. Chester St., Baltimore 31, Md.

19. July 7 1947 A. W. Tedesco
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 4, 1947 at 2 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 12, 1947 to July 4, 1947

and that I last saw him alive on June 4, 1947

Immediate cause of death	DURATION
Tuberculosis, pulmonary, far advanced, active.	10 months plus
Due to:	.....
Due to:	.....
Other conditions	.....

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Robert M. Cullison M. D. or other

R. M. CULLISON, M.D. CLIN. DIR.

Address: VETS. ADM. HOSP., FORT HOWARD, MD. Date signed: .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

05773 P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

186a

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months, 10 days

Hospital, Institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 2 months, 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Reisterstown
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Butler Rd
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Anna A. Grace

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Roland Grace

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): July 6, 1869

8. AGE: Years	Months	Days	If less than one day
77	11	26	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER
12. Name: Benjamin P. Ladley
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden name: Mary A. Wilson
15. Birthplace: Baltimore, Maryland

16. Informant: Hospital records
Address: Catonsville-28, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof July 4 1947 (month) (day) (year)
Cemetery or crematory: Mt Olivet
Location: Baltimore Md

18. Funeral director: Harry H Withe
Address: 410 Edmondson Ave

19. 7-3 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 2 19 47 at 12:10 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Cardiac failure	
Due to Dehydration	
Due to Cardio vascular disease	
Other conditions: accident fracture right femur	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of June 15 47
Where did injury occur? Catonsville (City or town) Baltimore (County) (State)
Injured at home, farm, industry, public place (where?) Hospital
Means of injury: fall on floor Injured at work? no

23. SIGNATURE: Gertrude Kieffer Asst Med Exam Edwin J Britto M. D. or other
Address: 1010 Leadenhall Date signed: 7-2-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

99

CERTIFICATE OF DEATH

BC 05774

Reg. Dist. No.

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 Days

Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Fort Howard, Maryland

How long in hospital or institution? 19 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: 5116 Chalgrove Ave, Pimlico, 15, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: See above.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: FRED GRANT

3.(b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lulu Grant

6.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): 3-12-01

8. AGE:

Years	Months	Days	If less than one day
46	4	4	..... hrs. ..... min.

9. Birthplace: Logansport, Ind.
(Town, county, and state)

10. Usual occupation: Optician

11. Industry or business:

FATHER
12. Name: Charles Grant
13. Birthplace: Indiana

MOTHER
14. Maiden name: Kathryn Bair
15. Birthplace: Indiana

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Ft. Howard, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 7/18/47 (month) (day) (year)
Cemetery or crematory: Mt Cooley Funeral Home
Location: Logansport Indiana

18. Funeral director: Howard N. Blight Jr.
Address: 4914 Belair Road

19. 7/17 (Date rec'd by registrar) 19 47 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 16, 1947, at 11:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 27, 1947, to July 16, 1947
and that I last saw him alive on July 16, 1947

	DURATION
Immediate cause of death: THROMBOSIS OF LEFT VERTEBRAL ARTERY AND BASILAR ARTERY	6 weeks
Due to: Cause Unknown	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: Substantiated Above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: P W Sanders MD (M. D. or other)

Address: V.A. Fort Howard, Md. Date signed: 7-16-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 056244

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 187 Days

Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Ft. Howard, Maryland

How long in hospital or institution? 187 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Port Deposit
(If outside city or town limits, write RURAL and give nearest town)

Street No. 180 Main Street
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-2

3.(a) FULL NAME: ROSS W. GRANT, JR.

3.(b) Social Security Number: 216-14-7425

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: ////// Barbara Grant

6.(c) If alive, give age: 21 years

7. Birth date of deceased (mo., day, yr.): 6-23-22

8. AGE: Years	Months	Days	If less than one day
25	1	8	..... hrs. ..... min.

9. Birthplace: Zion, Md. (Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business:

FATHER — 12. Name: Ross Grant

FATHER — 13. Birthplace: Unknown

MOTHER — 14. Maiden name: Mary Jones

MOTHER — 15. Birthplace: Maryland

16. Informant: Clinical Records, Vets. Adm. Hosp.

Address: Ft. Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 8-3-47 (month) (day) (year)

Cemetery or crematory: Private Mt Zoar

Location: Conowingo, Md

18. Funeral director: Lee Patterson Fred Patterson & Son

Address: Perryville Aiken, Md.

19. July 31 1947 (Date rec'd by registrar) John L. Cruelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 31, 1947 at 9:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 25, 1947, to July 31, 1947 and that I last saw him alive on July 31, 1947

Immediate cause of death	TUBERCULOSIS, PULMONARY BILATERAL WITH CAVITATION, CHRONIC	DURATION: unknown
Due to		
Due to		
Other conditions		

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: Substantiated Above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Milton Lansberg M. D. or other

Address: V.A. Fort Howard, Md. Date signed: 7-31-47

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13/a

CERTIFICATE OF DEATH

0577543

Reg. Dist. No.

1. PLACE OF DEATH:

County: Balto.

City or town: Raspeburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Ridge Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Raspeburg
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Ridge Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: MARY E. HACK

3.(b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Frank A. Hack

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 18, 1872

8. AGE: Years	Months	Days	If less than one day
74	9	12	..... hrs. ..... min.

9. Birthplace: Balto. Co., Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Ernest Weikert
13. Birthplace: Germany

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Mr. Henry Hack,
Address: Ridge Rd., Raspeburg, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 2, 1947 (month) (day) (year)

Cemetery or crematory: Zion Lutheran

Location: Stemmers Run, Md.

18. Funeral director: Loarkin Funeral Home

Address: 7401 Belair Road

19. July 31 1947 (Date rec'd by registrar) Mrs. A. I. Reifsnider Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 30th, 1947, at 6:45AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 1947 to July 30 1947

and that I last saw h[illegible] alive on July 29 1947

Immediate cause of death: acute dilatation

	DURATION
Cardiac Arrest, Acidosis	3 days
Congestive Cardiac Insufficiency	3 mos
Due to Glomerulo Interstitial Nephritis	5 yrs
Due to Arteriosclerosis, Malignant Hypertension	5 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Geo. L. Zimmerman M. D. or other

Address: 9858 Harford Rd Date signed: 7/31/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M


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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d 05776 37

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Balto.

City or town: Cockeysville

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days): 2

Stay in this community (yrs., or mos., or days): Lifetime

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Cockeysville Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Warren Rd.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Harry David. Haines.

3. (b) Social Security Number:

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married -

6 (b) Name of husband or wife: Rebecca V. Haines.

6(c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): Mch 28/67

8. AGE: Years: 80 Months: 3 Days: 4 If less than one day: hrs. min.

9. Birthplace: Balto Co. Md - (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Mill worker.

FATHER

12. Name: Andrew. Haines -

13. Birthplace: Md -

MOTHER

14. Maiden name: Catherine Trimmer.

15. Birthplace: Pa -

16. Informant: Mrs Harry Haines -

Address: Cockeysville Md - 5

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 7 9 47 (month) (day) (year)

Cemetery or crematory: Poplar Grove

Location: Cockeysville

18. Funeral director: J. Scott Brooks

Address: Sparks, Md.

19. 7-3- 47 (Date rec'd by registrar) 19 Wilmer C. Ensor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 2 1947, at 11 50 A. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 15- 1940, to July 2- 1947, and that I last saw him alive on 7/1 1947.

	DURATION
Immediate cause of death: Myocarditis	7yrs.
Due to: Arterio sclerosis.	
Due to: Senility -	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Wilmer C. Ensor M.D. M. D. or other

Address: Cockeysville Md Date signed: 7/2/47

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JUL 8 1947
BUREAU P.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

CERTIFICATE OF DEATH

05777

Reg. Dist. No. 41

1. PLACE OF DEATH:
County: Baltimore
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
Street No. Box 220 Old Battle Grove Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: George Fletcher Harman

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Katherine L. Harman
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 17, 1876

8. AGE: Years	Months	Days	If less than one day
70	6	24	hrs. min.

9. Birthplace: West Virginia (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business

FATHER
12. Name: Samuel Harman
13. Birthplace: W. Va.

MOTHER
14. Maiden name: Mary E. Judy
15. Birthplace: W. Va.

16. Informant: Mrs. Katherine L. Harman
Address: Box 220 Old Battle Grove Road

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 14, 1947 (month) (day) (year)
Cemetery or crematory: Oak Lawn
Location: Eastern Ave.

18. Funeral director: Roland L. Fiehs
Address: 112 Dundalk Ave.

19. 7/14/47 (Date rec'd by registrar) 19.. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 11th 1947 at 2:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 30 1947 to July 11 1947
and that I last saw h.. alive on July 7 1947

Immediate cause of death	DURATION
Cardiac Hemorrhage	5 min.
Due to: A-S-C-V-R Disease	10 yrs.
Due to:	
Other conditions: Chronic Myocarditis	10 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

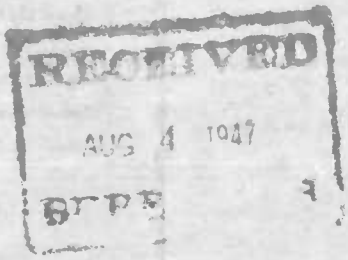
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: None Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. B. Davis M.D. M. D. or other
Address: Dundalk, Md. Date signed: 7/11/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING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AUG 4 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 108

05778

CERTIFICATE OF DEATH

Reg. Dist. No. 3

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 42 years, 18 days.

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 42 years, 18 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: ?

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Fred Hermann

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: --

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1878?

8. AGE: Years	Months	Days	If less than one day
69	?	?	hrs. min.

9. Birthplace: Maryland. (Town, county, and state)

10. Usual occupation: Bartender.

11. Industry or business: Store.

FATHER

12. Name: ?

13. Birthplace: ?

MOTHER

14. Maiden name: ?

15. Birthplace: ?

16. Informant: Hospital records.

Address: Catonsville- 28, Maryland.

17. Buried (Burial, cremation, or removal. Which?) Date thereof July 21, 1947 (month) (day) (year)

Cemetery or crematory: Spring Grove State Hospital

Location: Catonsville 28, Md.

18. Funeral director: Spring Grove State Hospital

Address: Catonsville 28, Md.

19. 7-21 (Date rec'd by registrar) 1947 Harry L. Miller Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 13, 1947, at 2:15 a M

21. I CERTIFY that death occurred on the date above etated; that I attended deceased from June 25, 1905, to July 13, 1947, and that I laet saw h im alive on July 13, 1947

	DURATION
Immediate cause of death: Right lower lobar pneumonia	48 hours
Due to: Chronic sclerotic coronary disease	indefinite
Due to: Generalized arteriosclerotic cardiovascular-renaldisease	"
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: As above.

PHYSICIAN: Please underline the canse to which death should he charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Meane of Injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D. (M. D. or other)

Address: Catonsville- 28, Md. Date signed: 7-16-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information called for. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RY
JUL 24 1947
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

05779

CERTIFICATE OF DEATH

Reg. Dist. No. 38

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

M

I

1. PLACE OF DEATH:
County Balto. Co.
City or town Govans
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2½ yrs.
Hospital, institution, or street address where death occurred: 812 Regester Ave
How long in hospital or institution? 2½ yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Co.
City or town Balto.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6210 Brook Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Mamie E. Hicks

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife William J. Hicks
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) July 15th 1870

8. AGE: Years	Months	Days	If less than one day
76	11	28	... hrs. ... min.

9. Birthplace Balto. City Md.
(Town, county, and state)
10. Usual occupation at home
11. Industry or business

FATHER
12. Name John Repline
13. Birthplace Unknown

MOTHER
14. Maiden name Katherine Grill
15. Birthplace Germany

16. Informant Wm J. Hicks
Address 6210 Brook Ave

17. Burial Date thereof 7/15/47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Parkwood
Location Balto. Md.

18. Funeral director Lassahn Funeral Home
Address 7401 Belair Rd.

19. July 14 1947 [signature] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13th 1947, at 5 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1-47 19..., to 7/13 1947
and that I last saw her alive on 7/13 1947

Immediate cause of death Coronary Thrombosis

DURATION

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other
Address [illegible] Date signed 7/14/47

VS A15 9-45-15M


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AUG 4 1947
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

45 f

06470

Reg. Dist. No.

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 hours

Hospital, institution, or street address where death occurred:
Veterans Administration Hospital

How long in hospital or institution? 4 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)

Street No. 24 Liberty Parkway
(If rural, give LOCATION)

2.(a) If veteran, name war: WWII ✓

3. (a) FULL NAME
MIKE W. HILLAS

3. (b) Social Security Number
213-09-3746

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: --

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): February 18, 1902

8. AGE:

Years	Months	Days	If less than one day
45	5	11	..... hrs. ..... min.

9. Birthplace: Greece
(Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business

FATHER
12. Name: William Hillas
13. Birthplace: Greece

MOTHER
14. Maiden name: ?
15. Birthplace: Greece

16. Informant: Clinical Records, Veterans Administration, Fort Howard, Md.
Address

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof 8/1/47
(month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery

Location: Baltimore, Md.

18. Funeral director: Howard M. Blight Jr. Howard Blight Funeral Home

Address: 4914 Belair Rd., Baltimore, Md.

19. 7-31 1947
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 29 19 47 at 7:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 29 19 47 to July 29 19 47 and that I last saw him alive on July 29 19 47

Immediate cause of death	DURATION
INTRAPHARYNGEAL HEMORRHAGE	Unknown
Due to: CARCINOMA OF NASOPHARYNX	Unknown
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: SUBSTANTIATED ABOVE

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Robert M. Cullison
R. M. CULLISON, M.D. M. D. or other

Address: VAH, Fort Howard, Md. Date signed: 7/30/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06471 P

46f

Reg. Dist. No. 31

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

I

VS A15

1. PLACE OF DEATH:

County: ~~Baltimore~~

City or town: Marriottsville Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 weeks

Hospital, Institution, or street address where death occurred:
Wards Chapel Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Marriottsville Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. Wards Chapel Road
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Hofstetter

Annie L. Hoff

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widowed

8.(b) Name of husband or wife: John Hofstetter

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): June 23, 1868

8. AGE: Years	Months	Days	If less than one day
79	1	5	..... hrs. ..... min.

9. Birthplace: Germany
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: at home

FATHER
12. Name: Unknown

13. Birthplace: Germany

MOTHER
14. Maiden name: Unknown

15. Birthplace: Unknown

16. Informant: Mrs. Alice Leonard

Address: Marriottsville Md

17. (Burial) (Burial, cremation, or removal. Which?) Date thereof 7/28/47 (month) (day) (year)

Cemetery or crematory: Oaklawn

Location: Baltimore Co., Md

18. Funeral director: John Ulrich Jr

Address: 2068 Orleans St, Balto

19. 7/28 19 47 A. W. Hedrick D
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 25, 1947, at 8 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 6, 1947, to July 25, 1947, and that I last saw h... alive on July 26, 1947

Immediate cause of death	DURATION
Carcinoma of Liver	
Due to	
Due to	
Other conditions: Chr. Valv. Hrt. Dis. Decompensation	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Wm. E. Martin
M. D. or other

Address: Randallstown, Md Date signed 7/29/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

92c 12C

CERTIFICATE OF DEATH

Reg. Dist. No. 05780 44

1.

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 Days

Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Ft. Howard, Md.

How long in hospital or institution? 4 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2001 Maryland Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: SAW

3. (a) FULL NAME: GEORGE W. HOOK

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: ///// Helen Hook

6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): 6-7-81

8. AGE: Years	Months	Days	If less than one day
66	1	21	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business:

FATHER
12. Name: Frederick Hook
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mattie Meredith
15. Birthplace: Maryland

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Ft. Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/31/47 (month) (day) (year)
Cemetery or crematory: St. Mary's Cemetery
Location: Baltimore, Md.

18. Funeral director: Wm. Cook, Inc.
Address: Balto., Md.

19. 7/29 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 27, 1947, at 10:40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 23, 1947, to July 27, 1947 and that I last saw him alive on July 27, 1947.

	DURATION
Immediate cause of death: Insufficiency and stenosis of aortic valve 92a	Unknown
Due to: Calcification of valve ring and valve cusps	Unknown
Due to:	
Other conditions: Severe arteriosclerosis of aorta; healed duodenal ulcer	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: Substantiated above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert M. Cullison M. D. or other

R. M. CULLISON, M.D. CLIN DIR.

Address: V.A.H. FT. HOWARD, MD. Date signed: 7-28-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a C5781

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:
County: Baltimore
City or town: (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs.
Hospital, institution, or street address where death occurred: 812 Register Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 15 Center Place
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: George R. Hoyer.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

B.(b) Name of husband or wife: L. Virginia Hoyer
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 30, 1870

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
77	0	18		

9. Birthplace: Harrisburg, Pa. (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business:

FATHER
12. Name: George Hoyer
13. Birthplace: Pa.

MOTHER
14. Maiden name: Justina
15. Birthplace: Pa.

16. Informant: J. Harry Prowell
Address: 15 Center Place, Dundalk
17. Removal (Burial, cremation, or removal. Which?) Date thereof: July 22, 1947 (month) (day) (year)
Cemetery or crematory: Harrisburg
Location: Harrisburg, Pa.
18. Funeral director: Roland L. Fuhrer
Address: 7112 Dundalk Ave.
19. July 19 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 19 1947 at 2:50 P.M.
21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from Jan 5, 1947 to July 18, 1947 and that I last saw him alive on July 18 1947.

Immediate cause of death	DURATION
Apoplexy	3 days.
Due to: Arteriosclerosis	
Due to: Hypertension	UNK.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings at operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

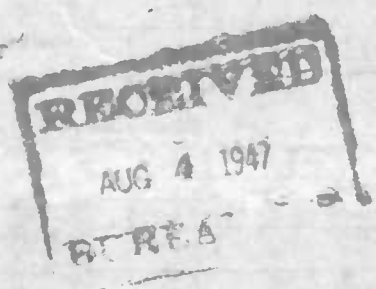
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: John S. Green M.D.
M. D. or other
Address: Lawson-Md. Date signed: July 19 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15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AUG 4 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

170d

05782 37

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Lutherville (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Seminary Ave. & May's Chapel Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: B ltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 8000 W. 34th Street

(If rural, give LOCATION)

2.(a) If veteran, name war: World War II

3.(a) FULL NAME: ROBERT L. HYLE

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: ———

6.(c) If alive, give age: ——— years

7. Birth date of deceased (mo., day, yr.): July 31, 1926

8. AGE: Years	Months	Days	If less than one day
20	11	14	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Seaman 1st Class

11. Industry or business: United States Navy

FATHER

12. Name: Howard K. Hyle

13. Birthplace: Maryland

MOTHER

14. Maiden name: Edna E. Stricklin

15. Birthplace: Maryland

16. Informant: Mrs. Edna E. Stricklin

Address: 8000 W. 34th St., Balto., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 17, 1947 (month) (day) (year)

Cemetery or crematory: Waugh Chapel Cemetery

Location: Harford County, Maryland

18. Funeral director: Chenoweth & Donovan

Address: 3615-17 Chestnut Ave., Balto., Md.

19. July 16 1947 (Date rec'd by registrar) Wilmer C. Enson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 14, 1947 19..... at 5:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Pronounced him dead — July 14 19 47.

and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
Fractured Skull	few Minutes
Due to (accidental)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of injury: July 14, 47

Where did injury occur? Lutherville (City or town) Balto (County) Md. (State)

Injured at home, farm, industry, public place (where?): High way

Means of injury: Motorcycle accident Injured at work?

23. SIGNATURE: John S. Green Jr. M. D.

(Deputy Medical Examiner) M. D. or other

Address: Towson 4 Md. Date signed: 7/16/47.

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JUL 23 1947
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

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05783

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 37 days

Hospital, Institution, or street address where death occurred:
Veterans Administration Hospital

How long in hospital or institution? 37 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1718 Jackson Street
(If rural, give LOCATION)

2.(a) If veteran, name war: WWII

3.(a) FULL NAME: RAYMOND JEFFERIES

3.(b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Dorothy Jefferies

6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): February 21, 1907

8. AGE: Years	Months	Days	If less than one day
40	4	11	....hrs. ....min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Pipefitter helper

11. Industry or business

FATHER
12. Name: Albert Jefferies
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden name: Charlotte Meske
15. Birthplace: Unknown

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Fort Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/5/47 (month) (day) (year)

Cemetery or crematory: Baltimore Natl Cemetery (Frederick Rd)

Location: Baltimore, Maryland

18. Funeral director: Howard M. Blight Jr. Blight Funeral Home

Address: 4914 Belair Road, Balto. Md.

19. 7-3 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 2 19 47 at 12:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 26 19 47 to July 2 19 47 and that I last saw him alive on July 2 19 47

Immediate cause of death	DURATION
CEREBRAL EDEMA, CAUSE UNDETERMINED	Indefinite
Due to	
Due to	
Other conditions: MENIERE'S SYNDROME	9 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: Tight brain with increased intracranial pressure Date of op. 7/1/47

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Robert M. Cullison
R. M. CULLISON, M.D. M. D. or other

Address: VAH, Ft. Howard, Md. Date signed 7/2/47

GMS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

05784 47

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Shawan - Cockeysville P.O.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Shawan - Cockeysville P.O.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Falls Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Andrew Johnson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Colored	married

6.(b) Name of husband or wife: Alice Johnson Charles
6.(c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.): Apr. 27, 1887

8. AGE: Years	Months	Days	If less than one day
60	2	26	hrs. min.

9. Birthplace: Balto. Co., Md.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:
FATHER 12. Name: Charles Johnson
FATHER 13. Birthplace: Balto. Co., Md.
MOTHER 14. Maiden name: Sarah Mack
MOTHER 15. Birthplace: Balto. Co., Md.
16. Informant: Thomas Beard
Address: Monkton, Md
17. Burial (Burial, cremation, or removal, which?) Date thereof July 26, 1947 (month) (day) (year)
Cemetery or crematory: Govans
Location: Cuba Rd., Cockeysville, Md
18. Funeral director: Lawson M. Broyles
Address: Govans, Md.
19. 7-26 1947 Wilmer C. Ensor
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 23 1947, at 9:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw him alive on 7-23 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	45 min
Due to: Hypertensive C-V. Disease	2 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: None. Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: None - Injured at work?

23. SIGNATURE: D. D. Caples M.D. Med. Exam.
M. D. or other
Address: Reisterstown, Md. Date signed 7-23-47

RECEIVED
JUL 29 1947
BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

05785 35
Reg. Dist. No. 35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Hereford - Rural (Monkton P.O.)
(If outside city or town limits, write RURAL, and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Hereford - Rural (Monkton P.O.)
(If outside city or town limits, write RURAL and give nearest town)

Street No.: York Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Annie Hayes Johnson

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Married

6.(b) Name of husband or wife: William C. Johnson

6.(c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): Sept 11, 1865

8. AGE:

Years	Months	Days	If less than one day
71	9	24	hrs. min.

9. Birthplace: Balto. Co., Md.
(Town, county, and state)

10. Usual occupation: Homemaker

11. Industry or business

FATHER
12. Name: John W. Hicks
13. Birthplace: Balto. Co., Md.

MOTHER
14. Maiden name: Eliza J. Turbaugh
15. Birthplace: Balto. Co. Md.

16. Informant: Roland H. Johnson
Address: 2605 Layton Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 8, 1947 (month) (day) (year)

Cemetery or crematory: Mt. Carmel

Location: Balto. Co., Md.

18. Funeral director: Landon M. Brooks

Address: Govans, Md.

19. 7/5 (Date rec'd by registrar) 1947 Mrs. Howard S. Marburg Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 5, 1947 at 1:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1938 to July 5, 1947 and that I last saw her alive on 19

Immediate cause of death	DURATION
Coronary Thrombosis	Instant
Due to Coronary Sclerosis	5 yrs.
Due to Generalized arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: R. Lee Hill M.D.
M. D. or other

Address: Cal. & 30th St. Date signed 7-5-47

RECEIVED
JUL 10 1947
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05786

13b

CERTIFICATE OF DEATH

Reg. Diat. No.

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp. Fort Howard, Maryland

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1738 Orleans St. Baltimore 31, Md.

(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3. (a) FULL NAME

GEORGE A. KEYES

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Married

6.(b) Name of husband or wife: Agnes Keyes

6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): May 30, 1890

8. AGE: Years	Months	Days	If less than one day
57	1	18	...hrs. ...min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Waiter

11. Industry or business

FATHER — 12. Name: Sol Keyes

FATHER — 13. Birthplace: Virginia

MOTHER — 14. Maiden name: Elizabeth Brown

MOTHER — 15. Birthplace: Virginia

16. Informant: Clinical Records, Vets. Adm. Hosp

Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 23, 1947 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery

Location: 5501 Frederick Ave., Balto. Md.

18. Funeral director: Wilson Funeral Home

Address: 1000 Brantly Ave. Balto., Md.

19. July 21 19 47 (Date rec'd by registrar) G. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 18 19 47, at 6:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 16 19 47, to July 18 19 47

and that I last saw him alive on July 18 19 47

Immediate cause of death	DURATION
Tuberculosis, pul. generalized	unknown
Hemorrhage, pulmonary, recent	
Due to: Cavitation, right apex	13 mos.
Due to:	
Due to:	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert M. Cullison R.M. CULLISON, M.D. CLINICAL DIRECTOR M. D. or other

Address: V.A. Fort Howard, Md. Date signed: 7-18-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

057873 S

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct name, is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Baltimore
City or town: McDonogh
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: McDonogh
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: FERDINAND KLOTZ

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: Sophia Klotz
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): June 22, 1869

8. AGE: Years: 78 Months: 0 Days: 21 If less than one day: hrs. min.

9. Birthplace: Germany
(Town, county, and state)

10. Usual occupation: Mechanic

11. Industry or business

FATHER 12. Name: Jacob Klotz
13. Birthplace: Germany

MOTHER 14. Maiden name: Not Known
15. Birthplace: Germany

16. Informant: Mr. Wm. O. Klotz (son)
Address: 107-10th Ave. Brooklyn Park-25

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Jul. 16. 1947
(month) (day) (year)
Cemetery or crematory: Westarn Cemetery
Location: Baltimore Md.

18. Funeral director: HENRY SANDER & SONS. INC.
Address: Baltimore Md.

19. 7/14/47 19.... E E Michaels MD
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 13., 1947 at 7½ Am

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from for 15 years 19.... to July 13 19.47
and that I last saw h... alive on July 13 - 19.47

	DURATION
Immediate cause of death: Coronary occlusion	Sudden
Due to: Coronary artery disease	15 yrs
Due to: Arterio Sclerosis	?
Other conditions: Senility	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: E E Michaels MD
M. D. or other
Address: Rockville Md Date signed: 7/14/47

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JUL 17 1947
BUREAU V E

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

164a

05788

CERTIFICATE OF DEATH

Reg. Diat. No. 461

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1503 Snyder ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Mary Madeline Kobaske

3. (b) Social Security Number:

4. Sex: F.
5. Color or race: W.
6.(a) Single, married, widowed, or divorced: Married.
6.(b) Name of husband or wife: Ignacian
6.(c) If alive, give age: 50 years
7. Birth date of deceased (mo., day, yr.): Sept 1900.
8. AGE: Years: 47 Months: Days: If less than one day: hrs. min.
9. Birthplace: New York N. Y. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: Gus Wallick
FATHER 13. Birthplace: unknown
MOTHER 14. Maiden name: unknown
MOTHER 15. Birthplace: New York State
16. Informant: Ignaic Kobaske
Address: 1503 Snyder
17. Burial (Burial, cremation, or removal. Which?) Date thereof: aug 3/49 (month) (day) (year)
Cemetery or crematory: Sacred Heart of Mary
Location: German Hill Road
18. Funeral director: Stefan J. Fialkowski Jr.
Address: 1000 S. Kenwood Ave
19. July 29/49 Mbearmine (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 29th 1949, at 12 30 P. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....
Immediate cause of death: Caused by Hanging —
Due to: —
Due to: —
Other conditions: —
(Include pregnancy within 3 months of death)

DURATION

Major findings of operations: Unpaid
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of: 7-29-49
Where did injury occur? Dundalk (City or town) Balto (County) Md (State)
Injured at home, farm, industry, public place (where?): Home
Means of injury: Hung self in cellar Injured at work? No

23. SIGNATURE: M D Evans M
Dep. Med. Examiner, Balto Co. (Official or other)
Address: Dundalk Md. Date signed: 7/29/49

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AUG 4 1941
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 163

CERTIFICATE OF DEATH

05789

Reg. Dist. No. 38

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH

County: Baltimore

City or town: Towson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 26 years

Hospital, institution, or street address where death occurred: 200 York Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Towson

(If outside city or town limits, write RURAL and give nearest town)

Street No. 200 York Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME

ETHEL LOFLIN Koch

3.(b) Social Security Number

213-12-7835

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: William A. Koch (deceased)

6.(c) If alive, give age: ////

7. Birth date of deceased (mo., day, yr.): February 18, 1886

8. AGE: Years	Months	Days	If less than one day
61	4	23	...hrs. ...min.

9. Birthplace: Harford County, Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At Home

FATHER

12. Name: Edwin W. Kieffer

13. Birthplace: Abingdon, Harford Co., Md.

MOTHER

14. Maiden name: Regina Loflin

15. Birthplace: Maryland

16. Informant: William Koch

Address: 200 York Rd., Towson, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 15, 1947 (month) (day) (year)

Cemetery or crematory: Abingdon Cemetery

Location: Abingdon, Harford Co., Maryland

18. Funeral director: John Burns Sons

Address: Towson, Maryland

19. July 14 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 12 1947 at 7:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19... to ...19...

and that I last saw h... alive on ...19...

Immediate cause of death	DURATION
(a) Carbon monoxide poisoning (illuminating gas) Suicide	7/12/47
Due to: Melancolia	1yr +
Due to: Hypertension Arteriosclerosis	10 yr Unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings at operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide? Illuminating Gas Date of July 12, 1947

Where did injury occur? Towson (City or town) Baltimore (County) Md. (State)

Injured at (home) farm, industry, public place (where?) Towson

Means of injury: ... Injured at work?

23. SIGNATURE: Rollin L. Hudson M.D. D.M.E. M. D. or other

Address: Towson Md. Date signed 7/12/47

RECEIVED
JUL 31 1947
BUREAU V E.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. 30 P.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:
(a) Baltimore ~~City~~, Maryland
(b) Street address 5501 Edmondson Ave.
(c) Hospital or institution:
Hood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30dys
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
05790
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1725 East 25th St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM NICHOLAS KOLB SR.

3 (b) If veteran, name war: no

3 (c) Social Security Account No. none

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Mary T. Kolb

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept. 5. 1868

8. AGE: Years 78 | Months 10 | Days 7 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Jeweler

11. Industry or business

FATHER
12. Name Adam Kolb
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret ?
15. Birthplace Germany

16 (a) Informant Mr. Adam B. Kolb (son)
(b) Address 1725 E. 25th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jul. 16. 1947 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location Baltimore County

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address Baltimore Md.

19 (a) 7/16/47 (Date rec'd by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July. 13. 1947 at 12.05 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 7 1947 to July 13 1947, and that I last saw him alive on July 12, 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage & Left hemiplegia	5 weeks
Due to Arteriosclerosis	5 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 1613 E. North Ave. Date signed 7-14-47

(7-14-47)

V S 150

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95c

05791

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH

County 2611 Hammonds Ferry Rd.

City or town Lansdown, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore

City or town Lansdowne

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2611 Hammonds Ferry Rd

(If rural, give LOCATION)

2.(a) If veteran, name war NO

3.(a) FULL NAME Frank A. Kraft

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 26, 1870

8. AGE: Years	Months	Days	If less than one day
77			....hrs. ....min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual occupation Balto. City Fire Dept.

11. Industry or business Retired

FATHER 12. Name Frederick Kraft

13. Birthplace Germany

MOTHER 14. Maiden name Julia Hook

15. Birthplace Germany

16. Informant Margaret V. Kraft

Address 2611 Hammonds Ferry Road

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/11/47 (month) (day) (year)

Cemetery or crematory Loudon Park

Location Baltimore, Md.

18. Funeral director William Cook Inc.

Address 1217 St. Paul Street

19. 7-9 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/8 1947, at 10.30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1947, to July 8 1947

and that I last saw h... alive on July 8 1947

Immediate cause of death	DURATION
Acute Heart Failure	
Due to Cronic Heart Disease	
Due to	
Other conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injury at work?

23. SIGNATURE Louis J. Glass MD M. D. or coroner

Address 526 Walbrook Ave Date signed 7/8/47

VS. A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

05796 P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 111a

CERTIFICATE OF DEATH

Reg. Diat. No. X X

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Days

Hospital, Institution, or street address where death occurred:

Vets. Adm. Hosp., Ft. Howard, Md.

How long in hospital or institution? 2 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (15)

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 4032 Cold Spring Lane

(If rural, give LOCATION)

2.(a) If veteran, name war: SAW

3. (a) FULL NAME: MORRIS LUDNER (LADNER)

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Widowed

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1878

8. AGE: Years: 69 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business:

FATHER — 12. Name: Not Known

13. Birthplace: Russia

MOTHER — 14. Maiden name: Not Known

15. Birthplace: Russia

16. Informant: Clinical Records, Vets. Adm. Hosp.

Address: Ft. Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 7-29-47 (month) (day) (year)

Cemetery or crematory: Hebrew Cemetery - Herring Run

Location: Baltimore, Md. - Phila. Rd

18. Funeral director: Jack Lewis

Address: Eutaw Place, Balto., Md.

19. 7/29 19 47 (Date rec'd by registrar) A.W. Kolnick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 28, 1947 at 7:50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 26, 1947 to July 28, 1947 and that I last saw him alive on July 28, 1947

	DURATION
Immediate cause of death: Pulmonary Infarction	4 Days
Due to: Cause Unknown	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert M. Cullison

R. M. CULLISON, M.D. CHIEF (M.D. or other)

Address: V.A.H. FT. HOWARD, MD. Date signed: 7-28-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05792

13

CERTIFICATE OF DEATH

Reg. Diat. No. 42

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 34 Days

Hospital, Institution, or street address where death occurred:
Vets. Adm. Hosp., Fort Howard, Maryland

How long in hospital or institution? 34 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Somerset Co.

City or town: Oriole
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Box 72
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3.(a) FULL NAME: CLIFFORD RAY LAIRD

3.(b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Byrl Laird

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 11-27-1896

8. AGE: Years	Months	Days	If less than one day
50	7	17	..... hrs. ..... min.

9. Birthplace: Westover, Maryland
(Town, county, and state)

10. Usual occupation: Waterman

11. Industry or business

FATHER
12. Name: William Laird
13. Birthplace: Maryland

MOTHER
14. Maiden name: Nora Bozman
15. Birthplace: Maryland

18. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Fort Howard, Md.

17. REMOVAL (Burial, cremation, or removal. Which?) Date thereof: July 14-47 (month) (day) (year)

Cemetery or crematory: Princess Ann.

Location: Princess Ann Md

18. Funeral director: Dale Daschields

Address: Princess Ann. Md

19. July 14 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 14, 1947, at 3:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10, 1947, to July 14, 1947 and that I last saw h... im ...alive on July 14, 1947

Immediate cause of death	DURATION
Far Advanced bilateral pulmonary tuberculosis	6 Mos.
Due to:	
Due to:	
Other conditions: Tuberculous laryngitis	4 Yrs. plus

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Robert M. Cullison
R. M. CULLISON, M.D. CLIN. M. D. or other

Address: V.A.H. FORT HOWARD, MD. Date signed: 7-14-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
JUL 17 1947
BUREAU OF S

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore 186a Reg. Dist. No. 41

CERTIFICATE OF DEATH CR 05793

1. PLACE OF DEATH:
(a) County Balto.
(b) City or town Sparrows Point P.O. (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital or institution: Bay Shore Park
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Pa. (b) County
(c) City or town Jewrstown (If outside city or town limits, write RURAL and give town)
(d) Street No. R.7 Box 3 (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) **FULL NAME** Thomas Jefferson Leach

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex M.

5. Color or race White

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Mary C. Leach

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 23, 1911

8. AGE: Years 36 | Months | Days | If less than one day hr. min.

9. Birthplace Mifflin, Pa. (Town, county, and state)

10. Usual occupation Water

11. Industry or business Mann Edge Tool Co.

FATHER 12. Name John J. Leach
13. Birthplace Pa.

MOTHER 14. Maiden Name Sarah Ubil
15. Birthplace Pa.

16 (a) Informant Mrs. Mary C. Leach
(b) Address Lewistown, Pa.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof July 21, 1947 (month) (day) (year)
(c) Cemetery or crematory
Location Lewistown Pa.

18 (a) Funeral director Roland L. Fisher
(b) Address 2122 Dundalk ave.

19 (a) 7/21/47 (Date rec'd by registrar) (b) J. J. Mcarmine (Registrar)

MEDICAL CERTIFICATION

20. Date of death July 20 1947 at 3:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw him alive on 19 .

Immediate cause of death Fracture neck — Duration
Due to Cervical vertebra
Due to C. Drowning
Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence July 20 1947
(c) Where did injury occur? Bay Shore Park, Balto. Md. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Public Place While at work? No (Specify type of place)
(e) Means of injury Drowning in Shallow water

23. Signature J. J. Mcarmine M.D. Deputy Medical Examiner (M.D. or other)
Address Dundalk Md Date signed 7/20/47

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

May Eckley Freund
6909 Ridgeway
Wife Mary Lead

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 183

CERTIFICATE OF DEATH

05794 44

Reg. Diat. No.

1. PLACE OF DEATH:

County: Balto

City or town: Middle River, Boxley Quarters

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 507 Northern Parkway

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME David Lee

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 28th 1937

8. AGE: Years 9 | Months 7 | Days | If less than one day hrs. min.

9. Birthplace Balto., Md.

(Town, county, and state)

10. Usual occupation School Boy

11. Industry or business

FATHER 12. Name Wm F. Lee

13. Birthplace Va

MOTHER 14. Maiden name Mildred Sweeney

15. Birthplace D. C.

16. Informant Mr. Wm F. Lee

Address 507 Northern Parkway

17. Burial Date thereof (month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory Moreland Park Cem

Location Taylor Ave.

18. Funeral director John F. Moran

Address Forty Second St & Greenmount Ave.

19. 7/29/47 19 John J. Connelly Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-27-47 19 at 9:40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Drowning	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide? Accidental Date of 7-27-47

Where did injury occur? Bolly Beach Bayou (City or town) (County) Public Place (State)

Injured at home, farm, industry, public place (where?)

Means of injury Drowning in Bolly Injured at work?

23. SIGNATURE M D Davis M.D.

Asst. Med. Examiner Balto. M. D. or other

Address Balto - W Date signed 7-27-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
AUG 5 1947
BUREAU 3

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46a

05795

Reg. Dist. No. .....

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County Baltimore
City or town Kensington
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
4301 Kensington Rd. Jf.
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Baltimore
City or town Kensington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4301 Kensington Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Harry B. Lehnert

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married

6.(b) Name of husband or wife Kathlyn E. Lehnert nee Franke. 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 8, 1894

8. AGE: Years	Months	Days	If less than one day
53		4	..... hrs. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual occupation Draftsman
11. Industry or business Dietrich Bros.
FATHER 12. Name Henry Lehnert
13. Birthplace Md.
MOTHER 14. Maiden name Mary Baker
15. Birthplace Md.
16. Informant Mrs. Kathlyn E. Lehnert
Address 4301 Kensington Rd
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/16/47 (month) (day) (year)
Cemetery or crematory Loudon Pk.
Location 3801 Frederick Rd.
16. Funeral director Harry H. Mitzfeld
Address 4101 Edmondson Ave
19. 7/16 19 47 A.W. Heinsohn Dep. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17 19 47, at 10:30 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 6 19 46 to July 17 19 47
and that I last saw h.. im alive on July 17 19 47

Immediate cause of death	DURATION
Coronary Thrombosis	1/2 hour
Due to	
Carcinoma of Esophagus	2 mos.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE George E. Vila M. D. or other
Address 802 Hyde Ave Date signed 7-17-47
Catonsville 28 Md.

Evidence for the changes made shown on G 110 7/14/47

05797

P.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

CERTIFICATE OF DEATH

Reg. Diat. No. .....

1. PLACE OF DEATH:

County: Baltimore (20)

City or town: Rural Middle River

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? years.

Hospital, Institution, or street address where death occurred: 1008 Fuselage Ave

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of motber)

State: Md County: Balto

City or town: Rural Middle River

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1008 Fuselage Ave

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME MRS. ETHEL LOVE

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband ~~or wife~~: William J. Love

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): February 25, 1891

8. AGE: Years: 56 | Months: 4 | Days: 6 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Pa. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: —

MOTHER FATHER

12. Name: Isaac Lowe

13. Birthplace: Fayetteville, Pa.

14. Maiden name: Jennie Lowe

15. Birthplace: Scottdale (Pa.

16. Informant: William J. Love, husband

Address: 1008 Fuselage av. Baltimore 20 Md.

17. ~~Burial~~, cremation, or removal. Which?: Removal Date thereof: 7/5/47 (month) (day) (year)

Cemetery ~~or crematory~~: Dic Kerson Run

Location: Dawson Pa.

18. Funeral director: William Cook Inc.

Address: 1217 St. Paul St.

19. July 5 1947 A. M. Hedrick

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 2 1947, at 11:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 28 1947, to July 2 1947

and that I last saw h.e.r. alive on July 2 1947

	DURATION
Immediate cause of death: Carcinomatosis, generalized	
Due to: Carcinoma, Primary of Right Breast	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma, Right breast

Date of op. Jan. 9, 1947

Autopsy results: None performed.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of Injury ..... Injured at work?

23. SIGNATURE: Irving R. Beck, MD M. D. or other

Address: 30 Chandelle Rd, Baltimore 20 Md. Date signed: July 3, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

05798

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:
County Baltimore
City or town Parkley Manor
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? .....
Hospital, institution, or street address where death occurred:
1616 Gait Road
How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Baltimore
City or town Parkley Manor
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1615 Gait Road
(If rural, give LOCATION)
2.(a) If veteran, name war ..... P

3. (a) FULL NAME Charles James Lyons

3. (b) Social Security Number 220-24-5960 Ford

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Della
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 11, 1874

8. AGE: Years 72 | Months 7 | Days 24 | If less than one day ..... hrs. ..... min.

9. Birthplace N.Y. Jersey
(Town, county, and state)
10. Usual occupation Engineer Retired
11. Industry or business .....
MOTHER FATHER
12. Name Charles J. Lyons
13. Birthplace N.Y.
14. Maiden name Whitmore
15. Birthplace .....
16. Informant Della Lyons
Address Parkley Manor Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/8/47 (month) (day) (year)
Cemetery or crematory Oak Lawn
Location Baltimore Co. Md
18. Funeral director Wilhelm & Son Inc
Address 1214 E. Fond St
19. July 7 1947 (Date rec'd by registrar) A. H. Yelnick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5 1947, at 6 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 4 1947 to July 5 1947 and that I last saw h[illegible] alive on July 4 1947

	DURATION
Immediate cause of death Cerebral apoplexy	Sudden
Due to Arteris-Sclerotic cardio vasicular disease	1 yr
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....
Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Geo. M. Baumgardner M. D. or other
Address Balto 6 Md Date signed 7-5-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06472 P.

131a

CERTIFICATE OF DEATH

Reg. Dist. No. 57

1. PLACE OF DEATH:
County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 yrs
Hospital, Institution, or street address where death occurred: 607 Stevenson Lane
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No. 607 Stevenson Lane
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Mary Ann MacDonnell

3.(b) Social Security Number: None

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Harry Hamilton MacDonnell
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): June 5 1867
8. AGE: Years: 80 Months: 1 Days: 17 If less than one day ..... hrs. ..... min.
9. Birthplace: York, York, Penna (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Henry Steeger
13. Birthplace: Penna

MOTHER
14. Maiden name: Caroline Kissinger
15. Birthplace: Penna

16. Informant: Mrs. Cora Thomas
Address: 607 Stevenson Lane, Towson
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/26/47 (month) (day) (year)
Cemetery or crematory: Loraine
Location: Govans, Md.
18. Funeral director: Wilhelm Cook Co.
Address: 1219 E. Fayette St.
19. July 24 1947 (Date rec'd by registrar) A.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 22 1947 at 10:45 P.M.

I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1946 to July 22 1947 and that I last saw h.. alive on July 21 1947

	DURATION
Immediate cause of death: Heart Failure	3 Days
Due to: Generalized Arterio-Sclerotic Cardio-Renal	
Due to: Vascular Disease	10 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) ..... (County) ..... (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Charles F. O'Donnell M.D. M. D. or other
Address: 7301 York Rd Towson Date signed 7/27/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

Reg. Dist. No. 05799 X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Baltimore
City or town Chase
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No. Eastern Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME James Philip Maddox.

3.(b) Social Security Number 215-10-6693

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married.

6.(b) Name of husband or wife Harriet E. Maddox
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 6th, 1907

8. AGE: Years	Months	Days	If less than one day
40	6		hrs. min.

9. Birthplace Baltimore County, Md. (Town, county, and state)
10. Usual occupation Cooper
11. Industry or business White Distillery

FATHER
12. Name Edward C. Maddox
13. Birthplace Baltimore County, Md.

MOTHER
14. Maiden name Ella B. Edwards
15. Birthplace Baltimore County, Md.

16. Informant Mrs. James P. Maddox
Address Eastern Ave. Chase P.O.

17. burial (Burial, cremation, or removal. Which?) Date thereof 7/9/47 (month) (day) (year)
Cemetery or crematory Ebenezer Methodist
Location Baltimore County

18. Funeral director Lansdowne Funeral Home,
Address 7401 Belair Road

19. 6/7-47 (Date rec'd by registrar) John E. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6th 19 47, at 6:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death (a) Chronic Myocarditis	4 Mos.
Due to (b)	
Due to (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide None Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE M B Davis M.D.
Address Dep. Med. Examiner, Balto. Co. Dispensary Date signed 7/6/47

RECEIVED
JUL 18 1947
BUREAU P.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932

05800

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Chase

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Chase

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Ebenezer Rd. & Ulrick Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Julia Marburg

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Joseph F. Marburg

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 26th, 1866

8. AGE: Years	Months	Days	If less than one day
81	5	24	hrs. min.

9. Birthplace: South Carolina (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name: Andrew De Martin

13. Birthplace: France

MOTHER 14. Maiden name

15. Birthplace: Germany

16. Informant: Mrs. Frank Crouch

Address: Ebenezer Road, Chase

17. burial (Burial, cremation, or removal. Which?) Date thereof: 7/23/47 (month) (day) (year)

Cemetery or crematory: St. Francis

Location: Abingdon, Maryland

18. Funeral director: Lasuahn Funeral Home

Address: 7401 Belair Road

19. July 20 1947 (Date rec'd by registrar) John C. Cromelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 20th 1947 at 5:20 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from APRIL 1947, to JULY 20 1947

and that I last saw h..ER..alive on JULY 20 1947

Immediate cause of death	DURATION
CONGESTIVE HEART FAILURE	4 MO.
Due to ARTERIO-SCLEROTIC	10 YRS
CARDIO-VASCULAR DISEASE	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Joseph Mucili M.D. M. D. or other

Address: 3 B MARS RD Date signed: 7/20/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
JUL 25 1947
BUREA

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

516

058802

CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Baltimore
City or town: Sparrows Point Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 70 Years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Sparrows Point Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 917 J Street
(If rural, give LOCATION)
2.(a) If veteran, name war: Civil War

3. (a) FULL NAME Africka Marshall
3. (b) Social Security Number

4. Sex: M
5. Color or race: Col.
6.(a) Single, married, widowed, or divorced: Widower
6.(b) Name of husband or wife: Alida
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): ? ? 1853

8. AGE: Years: 94 Months: Days: If less than one day ... hrs. ... min.

9. Birthplace: Prince Edward Co Va.
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business
FATHER 12. Name: Unknown
13. Birthplace
MOTHER 14. Maiden name: Unknown
15. Birthplace
16. Informant: Miles Marshall
Address: 914 J St Sparrows Pt
17. Removal Date thereof: July 6/47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory
Location: Meherrin Va.
18. Funeral director: Mrs Robt A. Elliott Dpt
Address: 1129 N. Caroline St
19. July 5 1947 A. W. Hedrick Asst State Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 2nd 1947, at 4:20 PM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1947 to July 2nd 1947
and that I last saw him alive on July 2nd 19

Immediate cause of death	DURATION
Carcinoma of Prostate	6 Mo.
Due to	
Due to	
Other conditions: Arterio sclerosis	unknown

(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: J H Thomas MD
Address: Turners Sta Md Date signed: 7/2/47

4

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

172 05801 44

Reg. Diat. No.

1

1. PLACE OF DEATH:
County: Baltimore
City or town: Parkton Dist No 1
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Box 263 Old North Pt. Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William P. Marszalek

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	

6.(b) Name of husband or wife: Lillian Mae Butschky
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 18- 1914

8. AGE: Years	Months	Days	If less than one day
33	11	9	hrs. min.

9. Birthplace: Balto Co. Md.
(Town, county, and state)
10. Usual occupation: Contractor
11. Industry or business:

FATHER
12. Name: Joseph Marszalek
13. Birthplace: Poland

MOTHER
14. Maiden name: Mary Zalenski
15. Birthplace: Balto

16. Informant: Mrs. Lillian M. Butschky
Address: Box 263 Old North Pt Rd

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 7-30-47 (month) (day) (year)
Cemetery or crematory: Holy Rosary
Location: Dundalk Pk Rd
18. Funeral director: John E. Connelly
Address: 48 Eastern Ave.

19. 7/28/47 (Date rec'd by registrar) 19 John E. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7-27-47 19 at 4 00 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
(a) Drowning.	
Due to (b)	
Due to (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 7-27-47.
Where did injury occur? Barren Pt. (City or town) Balto (County) Md. (State)
Injured at home, farm, industry, public place (where?) Public Place
Means of injury: Fell from boat Injured at work? No.

23. SIGNATURE: W. P. Davis M.D.
Wm. Fred. Hamm - Davis M. D. or other
Address: Dundalk - Md. Date signed: 7-27-47.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

CERTIFICATE OF DEATH

Reg. Dist. No. 05803 XX

1. PLACE OF DEATH:

County Balto.

City or town Evergreen Pk.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? —

Hospital, institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.

City or town Evergreen Pk.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Anton Joseph Mattheu

Andrew Mattheu

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years	Months	Days	If less than one day
70			..... hrs. ..... min.

9. Birthplace Balto. Co. (Town, county, and state)

10. Usual occupation Farmer.

11. Industry or business

FATHER — 12. Name John L. Mattheu

FATHER — 13. Birthplace Austria

MOTHER — 14. Maiden name Unknown

MOTHER — 15. Birthplace "

16. Informant James Mattheu

Address Stemmers Run, Baltimore County

17. Buried (Burial, cremation, or removal. Which?) Date thereof 7/18/47 (month) (day) (year)

Cemetery or crematory Holy Redeemer.

Location Belair Rd.

18. Funeral director John D Connelly.

Address 418 Eastern Ave. Essex 21, Md.

19. 7/17/ 1947 John D Connelly. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 1947 at 7:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1, 1947, to July 15, 1947 and that I last saw him alive on July 14, 1947

Immediate cause of death	DURATION
Chronic interstitial nephritis	?
Chronic mitral regurgitation	?
Due to Arterio-sclerosis	?
Myocardial insufficiency	3 days
Due to Pulmonary edema	1 day
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work

P. B. Bronaukas, M.D.

P. Benedict Bronaukas, M.D.

23. SIGNATURE ..... M. D. or other

Address 3037 O'Donnell St Date signed 7-16-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

3037

RECEIVED
AUG 5 1947
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05804

Reg. Diat. No. 32

1. PLACE OF DEATH:
County Baltimore
City or town Mount Wilson, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr., 8 mos., 29 days
Hospital, Institution, or street address where death occurred Mt. Wilson Branch, Md. Tuberculosis Sanatorium
How long in hospital or institution? 1 yr., 8 mos., 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Pr. Geo. Co., Md.
City or town Bladensburg (If outside city or town limits, write RURAL and give nearest town)
Street No. 4714 Annapolis Road (If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME: Mr. David H. McGaha

3.(b) Social Security Number: # Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Ethel J. McGaha
6.(c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.): May 11, 1890

8. AGE: Years	Months	Days	If less than one day
57	2	19	..... hrs. ..... min.

9. Birthplace: Dickerson, Maryland (Town, county, and state)
10. Usual occupation: Clerk
11. Industry or business

FATHER
12. Name: John W. McGaha
13. Birthplace: Frederick Co., Md.

MOTHER
14. Maiden name: Manaiel Smith
15. Birthplace: Virginia

16. Informant: David H. McGaha
Address: 4714 Annapolis Rd., Bladensburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/1/47 (month) (day) (year)
Cemetery or crematory: Hyattsville Cemetery
Location: Hyattsville, Maryland
18. Funeral director: Francis Gasch & Son
Address: Hyattsville, Maryland

19. July 30, 1947 (Date rec'd by registrar) Earl T. Webster Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 30, 1947 at 4:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 1, 1945 to July 30, 1947 and that I last saw him alive on July 30, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	2 yrs. 9 mos.
Due to: Tubercle Bacilli	
Due to:	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operations: No operation Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Stewart S. Shaffer M.D. M. D. or other
Address: Mount Wilson, Md. Date signed 7/30/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
AUG 4 1947
BUREAU V. E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131 B

05806

CERTIFICATE OF DEATH

Reg. Diat. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 68 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)
Street No. 62 Harlem Lane (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Caroline Louise McKenzie

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 25-1879

8. AGE: Years: 68 Months: Days: If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business
FATHER 12. Name: John G. Erdman
13. Birthplace: Germany
MOTHER 14. Maiden name: ?
15. Birthplace: ?
16. Informant: Thomas M. Erdman
Address: 504 N. Ellwood Ave
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 7-9-1947 (month) (day) (year)
Cemetery or crematory: Mt. Olivet
Location: Baltimore - Md
18. Funeral director: Edw. J. MacNabb
Address: Catonsville - Md.
19. 7-9-1947 (Date rec'd by registrar) Harry L. Miller Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 6 1947 at 9:35 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 22 1935 to July 6 1947 and that I last saw her alive on July 6 1947

	DURATION
Immediate cause of death: Hypertensive heart disease	4½ yrs.
Due to: Mitral myocardial degeneration	Unknown
Due to: Congestive heart failure	
Other conditions: Chr. Nephritis	unknown

(Include pregnancy within 3 months of death)

Major findings of operations: none Date of op.: —
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work? —

23. SIGNATURE: T. M. Herring M.D.
Address: 203 Ingleside Ave Catonsville 28 Md M.D. or other
Date signed: 7/8/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.


RECEIVED
JUL 10 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83L

CERTIFICATE OF DEATH

05807

Reg. Dist. No. XX

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 Days

Hospital, Institution, or street address where death occurred:
Vets. Adm. Hosp., Fort Howard, Md.

How long in hospital or institution? 3 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (13)
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1837 N. Montford Ave.,
(If rural, give LOCATION)

2.(a) If veteran, name war: SAW ✓

3. (a) FULL NAME: MICHAEL McKEWEN

3. (b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Widowed

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 3-14-71

8. AGE: Years	Months	Days	If less than one day
76	3	27	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business:

FATHER
12. Name: John McKewen
13. Birthplace: Maryland

MOTHER
14. Maiden name: Ellen Grogan
15. Birthplace: Maryland

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 16th 1947 (month) (day) (year)

Cemetery or crematory: Balto National

Location: Fredrick Road

18. Funeral director: Leo G. Meads

Address: 1701-03 N. Patterson Park Ave

19. 7/14 1947 (Date rec'd by registrar) A.W. Medinah Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 12, 1947, at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 9, 1947, to July 12, 1947, and that I last saw him alive on July 12, 1947.

	DURATION
Immediate cause of death: Cerebral Thrombosis	3 Days
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert M. Cullison
R.M. CULLISON, M.D. CLIN. M.D. or other

Address: V.A.H. FORT HOWARD, MD. Date signed: 7-12-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

157a 05808

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:

County: Balto.

City or town: Middle River

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred: 9 Propeller Drive

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Balto

City or town: Middle River

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 9 Propeller Drive

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME: Donna Lynn McNabb

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife .....

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan 3rd 1947

8. AGE:

Years	Months	Days	If less than one day
	6	4	..... hrs. ..... min.

9. Birthplace: Balto. Md. (Town, county, and state)

10. Usual occupation .....

11. Industry or business .....

FATHER

12. Name: Donald McNabb

13. Birthplace: Tenn.

MOTHER

14. Maiden name: Kathleen Tipton

15. Birthplace: Tenn.

16. Informant: Donald McNabb

Address: 9 Propeller Drive

17. Removal (Burial, cremation, or removal. Which?) Date thereof 7/8/47 (month) (day) (year)

Cemetery or crematory: Johnson City

Location: Tennessee

18. Funeral director: William Cook Inc.

Address: 1217 St. Paul St.

19. July 8 1947 (Date rec'd by registrar) A. W. Yedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 7th 1947 at 12 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 5 1947 to July 6 1947 and that I last saw h.. alive on June 28 1947

Immediate cause of death	DURATION
Hydrocephalus	
Due to: Congenital myelomeningocele	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Alexander J Schaffer, M.D. M. D. or other

Address: E. E. Eager st. Date signed July 7, 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, if the correct one is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13b

05809

Reg. Dist. No. 32

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County: Baltimore

City or town: Mount Wilson
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 0 yrs., 8 mos., 9 days

Hospital, Institution, or street address where death occurred: Mt. Wilson Branch, Md. T. B. Sanatorium

How long in hospital or institution? 0 yrs., 8 mos., 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 761 W. Fayette Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mr. John Meyers

3.(b) Social Security Number: 213-12-2445

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 12, 1902

8. AGE: Years	Months	Days	If less than one day
44	6	21	hrs. min.

9. Birthplace: Newark, New Jersey
(Town, county, and state)

10. Usual occupation: Painter

11. Industry or business:

FATHER
12. Name: Fred Meyers
13. Birthplace: Newark, New Jersey

MOTHER
14. Maiden name: Emma ?
15. Birthplace: Newark, New Jersey

16. Informant: Mr. John Meyers
Address: 761 W. Fayette St., Balto., Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: July 11, 1947
(month) (day) (year)

Cemetery or crematory: Almshouse Cemetery

Location: Texas, Maryland

18. Funeral director: Frank Newell & Sons
Address: Pikesville, Maryland

19. July 3, 1947
(Date rec'd by registrar)

Earl T. Webster
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 3, 1947 at 3:05 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from October 24, 1946, to July 3, 1947 and that I last saw him alive on July 3, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	3 yrs. 3 mos.
Due to: Tubercle Bacilli	
Due to:	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operations: No operation — Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: B. F. Siegel M.D.
M. D. or other

Address: Mt. Wilson, Md. Date signed: 7/3/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
JUL 15 1947
BUREAU of

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05810

Reg. Dist. No. 32

1. PLACE OF DEATH:

County: Baltimore

City or town: Mount Wilson
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 0 yrs., 2 mos., 18 days

Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. T.B. Sanatorium

How long in hospital or institution? 0 yrs., 2 mos., 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll Co.

City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)

Street No. 31 Church Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Mr. Melvin E. Michael

3. (b) Social Security Number: 579-07-1072

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Mae Michael

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): November 26, 1903

8. AGE: Years	Months	Days	If less than one day
43	7	20	..... hrs. ..... min.

9. Birthplace: Union Bridge, Maryland
(Town, county, and state)

10. Usual occupation: Factory Worker

11. Industry or business:

FATHER — 12. Name: Charles Michael

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Anna Dern

MOTHER — 15. Birthplace: Frederick Co., Md.

16. Informant: Melvin E. Michael

Address: 31 Church St., Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 20, 1947 (month) (day) (year)

Cemetery or crematory: Pleasant Valley Cemetery

Location: Westminster, Maryland

18. Funeral director: D. A. Bankard

Address: Westminster, Maryland

19. July 16, 1947 (Date rec'd by registrar) Earl T. Webster Registrar

Rec'd - 7-19-47 Doris Nichols mm

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 16, 1947 at 11:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 28, 1947, to July 16, 1947 and that I last saw him alive on July 16, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	10 mos.
Due to: Tubercle Bacilli	
Due to:	
Other conditions: Tuberculous Laryngitis	3 mos.

(Include pregnancy within 3 months of death)

Major findings of operations: No operation Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Stewart S Shaffer M.D.
M.D. or other

Address: Mount Wilson, Md. Date signed: 7/16/47

M

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
JUL 21 1947
BUREA 8

94a

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 35

05811

1 PLACE OF DEATH
County Baltimore
Village or City Parkton (No. ____ St.: ____ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Hester Jane Miller

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
Female	White	Widow

6 DATE OF BIRTH: July (Month) 30 (Day), 1871 (Year)

7 AGE: 68 yrs. 11 mos. 9 ds. (If LESS than 1 day ___ hrs. or ___ min.?)

8 OCCUPATION
(a) Trade, profession or particular kind of work — None
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Baltimore Co. Md.

PARENTS

10 NAME OF FATHER John Kelbaugh

11 BIRTHPLACE OF FATHER (State or country) Balto. Co. Md

12 MAIDEN NAME OF MOTHER Henrietta Hare

13 BIRTHPLACE OF MOTHER (State or Country) Balto. Co Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ruth M. Whitcraft
(Address) Parkton, Md

15 Filed July 11 1947 Charles J. Fuchs Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July (Month) 9 (Day), 1947 (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 1943 to July 9, 1947
that I last saw h[illegible] alive on July 9, 1947
and that death occurred on the date stated above, at 12:18 P. m.
The CAUSE OF DEATH * was as follows:
Coronary thrombosis

(Duration) ___ yrs. ___ mos. ___ ds.

Contributory Secondary: Arterio-sclerosis
Hypertension.

(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) O. H. France M. D.
7/9/47 1947 (Address) Parkton Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)
At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Robert M. Harding — DATE OF BURIAL: July 12, 1947

20 UNDERTAKER: Forrest Baptist Cemetary — ADDRESS: Seven Valleys Pa.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

M

I

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At Home,* and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum,* etc., *Carcinoma, Sarcoma,* etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia,*" "PUERPERAL *peritonitis,*" *etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

RECEIVED JUL 18 1947

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05812

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:

County: Baltimore

City or town: Mount Wilson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 0 yrs., 2 mos., 3 days

Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium

How long in hospital or institution? 0 yrs., 2 mos., 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Garrett Co.

City or town: Grantsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. ✓

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mr. Martin Luther Miller

3.(b) Social Security Number: 217-07-7956

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 29, 1904

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
42	6	9		

9. Birthplace: Grantsville, Maryland (Town, county, and state)

10. Usual occupation: Mill Worker

11. Industry or business

FATHER — 12. Name: Wilson Miller

FATHER — 13. Birthplace: Grantsville, Maryland

MOTHER — 14. Maiden name: Lydy Wicmen

MOTHER — 15. Birthplace: Grantsville, Maryland

16. Informant: Martin Luther Miller

Address: Grantsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 12, 1947 (month) (day) (year)

Cemetery or crematory: Grantsville Cemetery

Location: Grantsville, Maryland

18. Funeral director: William Winterberg

Address: Grantsville, Maryland

19. July 8, 1947 (Date rec'd by registrar) Earl T. Webster Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 8, 1947 at 9:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 5, 1947 to July 8, 1947 and that I last saw him alive on July 8, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	4 yrs.
Due to: Tubercle Bacilli	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: No operation Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: B. J. Siegel M.D. M.D. or other

Address: Mount Wilson, Md. Date signed: 7/8/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
JUL 15 1947
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

45a 05813 38

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County: Baltimore

City or town: Stonleigh (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Annacost Nursing Home 812 Registin Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Towson (If outside city or town limits, write RURAL and give nearest town)

Street No. 19 Linden Terrace (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Frances F. Mountcastle

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	widow

6.(b) Name of husband or wife: Frank E. Montcastle 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept. 7, 1887

8. AGE: Years: 59 Months: Days: If less than one day: hrs. min.

9. Birthplace: Va. (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER 12. Name: Farwell Bradley

13. Birthplace: Va.

MOTHER 14. Maiden name: Mary Marston

15. Birthplace: Va.

16. Informant: Ralph F. M. Address 202 Ridge Ave. Towson, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 3, 1947 (month) (day) (year)

Cemetery or crematory: Loudon Park

Location: Fred. Ave. Balto. Md.

18. Funeral director: John O. Mitchell & Sons

Address: 1600 Eutaw Place

19. 7/3 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 1, 1947, at 10:20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 1947 to July 1 1947 and that I last saw h alive on July 30 1947

Immediate cause of death	DURATION
Respiratory Failure	
Due to Myocardial Infarction	4 Days
Due to Squamous Cell Carcinoma of Labia	8 Months
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Charles F. O'Donnell M.D. M. D. or other

Address: 730 York Rd. Date signed: 7/7/47

730

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct name is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

05814 P

CERTIFICATE OF DEATH

Reg. Diat. No. .....

1. PLACE OF DEATH:
County Baltimore.
City or town Essex
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? .....
Hospital, institution, or street address where death occurred:
8240 Eastern ave
How long in hospital or institution? 15 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State ..... County .....
City or town Same
(If outside city or town limits, write RURAL and give nearest town)
Street No. .....
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3.(a) FULL NAME Evelyn Myers.

3.(b) Social Security Number

4. Sex: Fem.
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Divorced.
6.(b) Name of husband or wife .....
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Jan 13/1906
8. AGE: Years 41 Months 6 Days 7 If less than one day ..... hrs. ..... min.
9. Birthplace Cleveland Ohio.
(Town, county and state)
10. Usual occupation Wife.
11. Industry or business .....

FATHER
12. Name Chas Hartwick.
13. Birthplace Cleveland O.

MOTHER
14. Maiden name Louise Banks.
15. Birthplace Cleveland O.

16. Informant Mrs. Louise Banker
Address Essex Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7 23 47 (month) (day) (year)
Cemetery or crematory Oak Lawn
Location Balto Co Md
18. Funeral director A J Burgdenske
Address 1407 Eastern Ave R d

19. July 21 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1947 at 8 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Coronary occlusion	
Due to Following pneumonia	
Due to Epileptic seizure.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....
..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE D McCormick M.D.
M.D., or other
Address Deputy Medical Examiner Dundalk, Md Date signed 7/20/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Information added in red obtained from funeral director over telephone. 8/8/47 dm

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

05815

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:
County Baltimore
City or town Woodlawn (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Ridge Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Woodlawn (If outside city or town limits, write RURAL and give nearest town)
Street No. Ridge Road (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME August Tebel

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Louise Tebel
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) December 13, 1871

8. AGE: Years	Months	Days	If less than one day
75	7	9	..... hrs. ..... min.

9. Birthplace Baltimore County, Maryland (Town, county, and state)
10. Usual occupation Farmer
11. Industry or business

FATHER
12. Name George Tebel
13. Birthplace Unknown.

MOTHER
14. Maiden name Mary Gruenne
15. Birthplace Unknown

16. Informant Mrs Louise Tebel
Address Ridge Road, Woodlawn
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 25, 1947 (month) (day) (year)
Cemetery or crematory Woodlawn
Location Woodlawn, Md
18. Funeral director E. Willis Lanahan
Address 4510 Liberty Heights, Balto.
19. 7/22/ 1947 Wm. E. Martin
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 1947, at 11:55 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 8 1947, to July 22, 1947
and that I last saw h alive on July 22, 1947

Immediate cause of death	DURATION
Cerebral hemorrhage	
Due to Cardio-vascular Dis	
Due to	
Other conditions	
(Include pregnancy within 3 months of death)	

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Wm. E. Martin M. D. or other
Address Randallstown Date signed 7/23/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RE
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RECEIVED
AUG 8 1947
BUREAU U S

POST OFFICE
RANDALLSTOWN, MD.

DR. WILLIAM E. MARTIN

PHONE, ROSLYN 1374 J-1

RESIDENCE
HARRISONVILLE, MD.

HOURS: 8 TO 9 A. M. 1 TO 2 AND 6 TO 8 P. M. NO CALLS OR OFFICE HOURS ON TUESDAYS

FOR _____

ADDRESS _____ AGE _____

R

I have included all data available from this on copy of death certificate and Burial Permit—

Wm. E. Martin

DATE _____ M. D. REG. 507

MUCH TIME CAN BE SAVED BOTH PATIENT AND DOCTOR BY PHONING CALLS AS EARLY IN THE DAY AS POSSIBLE

RANDALLSTOWN PHARMACY

WALTER G. MUSGROVE, Ph. G., Prop.

Community Building, Randallstown, Maryland

Phones, Roslyn 1008 or 1009

RECEIVED
AUG 8 1947
BUREAU OF

RECEIVED
8 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

05816

Reg. Dist. No. 35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH

County: Baltimore

City or town: White Hall R F D

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 72 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Baltimore

City or town: White Hall R F D

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mary Susan Nelson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Henry Nelson

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 22. 1865

8. AGE:

Years	Months	Days	If less than one day
82	4	19	hrs. min.

9. Birthplace: Balto Co Md

(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER

12. Name: Eedmond Sutton

13. Birthplace: Balto Co. Md

MOTHER

14. Maiden name: Sarah Wiseman

15. Birthplace: Balto Md

16. Informant: Mrs. Clarence Evans

Address: White Hall, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 24 1947 (month) (day) (year)

Cemetery or crematory: West Liberty

Location: White Hall, Md

18. Funeral director: Howard S. Markline

Address: White Hall Md

19. July 22 1947 Mrs. Howard S. Markline

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 21 1947, at 7 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 14 1947, to July 21 1947

and that I last saw her alive on July 20 1947

Immediate cause of death	DURATION
Chronic myocarditis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: A. M. France M. D. or other

Address: Parkton, Md Date signed 7/22/47

RECEIVED
JUL 24 1947
BUREAU C &

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. [illegible]

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: (a) Baltimore ~~City~~, Maryland
(b) Street address 1214 Overbrook Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County 05817
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1214 Overbrook Road (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME MARY ANN NIZER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or ~~wife~~ John Lyman Nizer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 29, 1863

8. AGE: Years 83 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name J. Conrad Appell
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Ellen Judge
15. Birthplace Ireland

16 (a) Informant Mrs. Gertrude Michel - dght.
(b) Address 3732 Tudor Arms Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/8/47 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Baltimore
Location North Ave. & Rose St. Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) Filed July 8 1947 (b) [illegible] Registrar
(Date rec'd by registrar)

JUL. 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4 1947, at 10A.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1937, to July 2 1947 and that I last saw h~~e~~r alive on July 2 1947.

Immediate cause of death	Duration
Senile Myocardial Degeneration	
Due to Generalized Arterio Sclerosis.	
Other Conditions Chron. Nephritis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank J. Ayd M. D.
Address 3005 E Monument St Date signed July 7/47

INSTRUCTIONS FOR MEDICAL CERTIFICATION

WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

For additional discussion of this subject see PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.

JUL - 8 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05818

61

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Catonsville Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Violet Grove
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Raymond Abernueller

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 31 1878

8. AGE: Years: 69 Months: 1 Days: 19 If less than one day: hrs. min.

9. Birthplace: Austria
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER
12. Name: Not Known
13. Birthplace: " "

MOTHER
14. Maiden name: " "
15. Birthplace: " "

16. Informant: Raymond C. Packe
Address: Colgate Md

17. Burial
(Burial, cremation, or removal. Which?) Date thereof: 7-21-47 (month) (day) (year)

Cemetery or crematory: Cathedral
Location: Baltimore Md

18. Funeral director: Geo. A. Tyler
Address: Catonsville Md

19. 7-19 1947 (Date rec'd by registrar) Harry D. Miller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 18 1947, at 3 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19 1947, to July 18 1947 and that I last saw him alive on July 17 1947

Immediate cause of death	DURATION
Coronary Thrombosis	2 hr.
Due to: Coronary Sclerosis	5 yr. (?)
Due to:	
Other conditions: Diabetes Mellitus	10 yr.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Wilmer K. Fallaw M.D.
M. D. or other
Address: Catonsville 28, Md. Date signed: 7-18-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
JUL 21 1947
BUREAU OF S

STATE OF MD.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

168

Registered No. 44

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — Turner's Station
(b) Street address — Pier - Gas & Elec. Coal Yard
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Found Pier-Turner's Station, Md.
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DOROTHY O'BRIAN

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
35 ?			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 27-47 (month) (day) (year)
(c) Cemetery or crematory Texas Amb. Home
Location Texas Md.

18 (a) Funeral director John E. Connelly
(b) Address 410 Eastern Ave.

19 (a) Aug 27-47 (Date rec'd by registrar) (b) John E. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23, 1947, at 10 a M

21. I certify that I took charge of the remains described above, held an autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractures of mandible and maxillary bones
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ? - 1947 at ? M.
(b) Where did injury occur? ?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury Homicide due to blunt force.

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 7-23-47

VS 151

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

05820

Reg. Dist. No. 32

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Pikesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Pikesville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 12 Claredon avenue

(If rural, give LOCATION)

2.(a) If veteran, name war: ---

3.(a) FULL NAME: MARY A. O'KEEFE

3.(b) Social Security Number: -----

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Widowed

6.(b) Name of husband or wife: James M. O'Keefe

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 13, 1869

8. AGE: Years	Months	Days	If less than one day
77	8	23	..... hrs. ..... min.

9. Birthplace: Lutherville, Maryland (Town, county, and state)

10. Usual occupation: At Home

11. Industry or business:

FATHER — 12. Name: Martin Patrick Conner

FATHER — 13. Birthplace: Ireland

MOTHER — 14. Maiden name: Bridget Murray

MOTHER — 15. Birthplace: Ireland

16. Informant: Mr. James O'Keefe

Address: 7 Wendover road

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/9/47 (month) (day) (year)

Cemetery or crematory: New Cathedral Cemetery

Location: Old Frederick road

18. Funeral director: Chas J. Evans & Son

Address: 118 W. Mt Royal Ave

19. 7-7-1947 (Date rec'd by registrar) Dr E E Nichols Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 6 19 47 at 330 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10 19 47 to July 6 19 47

and that I last saw h.. alive on July 5 19 47

Immediate cause of death: Cerebral Hemorrhage — DURATION: 1 Mo.

Due to: Arterial hypertension — 2

Due to: Arterio Sclerosis — 7

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

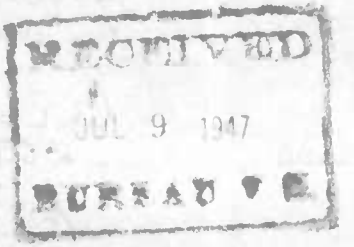
Means of injury: Injured at work?

23. SIGNATURE: E E Nichols M.D. M. D. or other

Address: Pikesville 8 Md. Date signed: 7-7-47

Dr. E. E. Nichols
1402 Reisterstown road

Pikesville 259



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131 a

06473 ?

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year, 8 months, 13 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 1 year, 8 months, 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 2818 Prisstman St.

(If rural, give LOCATION)

2.(a) If veteran, name war: -

3.(a) FULL NAME: Margaret Elsie O'Neal

3.(b) Social Security Number: - none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	divorced

6.(b) Name of husband or wife: Verner Roy O'Neal

6.(c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): September 15, 1889

8. AGE: Years	Months	Days	If less than one day
57	10	13	..... hrs. ..... min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: teacher

11. Industry or business: school

FATHER

12. Name: Edwin Thomas Cheethan

13. Birthplace: OHIO

MOTHER

14. Maiden name: Lelia Frances Rappold

15. Birthplace: Virginia

16. Informant: Hospital Records

Address: Catonsville 28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/31/47 (month) (day) (year)

Cemetery or crematory: Western

Location: Baltimore Md.

18. Funeral director: Wilhom Cobb Inc

Address: 1219 E Fort Ave

19. 7/30 1947 (Date rec'd by registrar) A. Wikdich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 28 19 47 at 4:05 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from November 15 19 45, to July 28 19 47 and that I last saw her alive on July 28 19 47

Immediate cause of death	DURATION
Cerebral hemorrhage of the right globus-pallidus (massive)	28 hours
Due to: Chronic hypertensive cardio-vascular renal disease	Indef.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: as above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Isadore Tuerk M. D. or other

Address: Catonsville 28, Md. Date signed 7/29/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information called for. Be sure the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 2-45-15M

M A F Rios 24 S Broadway

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH 83a

05821 Reg. Diat. No. 38

1. PLACE OF DEATH:
County Baltimore
City or town Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: 221 Dosley Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Baltimore
City or town Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No. 221 Dosley Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Dietrich F. Onnen Sr

3.(b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widower
6.(b) Name of husband or wife: Elma W Onnen
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): July 8 1865
8. AGE: Years 82 | Months 8 | Days 4 | If less than one day ..... hrs. ..... min.
9. Birthplace: Essen Germany (Town, county, and state)
10. Usual occupation: Pharmacist
11. Industry or business: Self
FATHER 12. Name: Owner
13. Birthplace: Germany
MOTHER 14. Maiden name: Unknown
15. Birthplace: Germany
16. Informant: Mrs Charles B Leonard
Address: 221 Dosley Ave Towson Md
17. Burial, cremation, or removal. Which?: Burial Date thereof: 7/15/47 (month) (day) (year)
Cemetery or crematory: Woodlawn
Location: Woodlawn Md
18. Funeral director: Wilhelm Bros Inc
Address: 1217 H Fort Ave
19. 7/14 1947 (Date received by registrar) A W Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 12 1947, at 7:15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1st 1947 to July 12th 1947 and that I last saw him alive on July 12 1947

	DURATION
Immediate cause of death: Cerebral Hemorrhage	5 days
Due to: Cerebral Arterio-Sclerosis	Long yrs
Due to: Hypertension	Long yrs
Other conditions: Right side hemiplegia	5 days

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury: Injured at work?

23. SIGNATURE: A. F. Rios M. D. or other
Address: 24 S. Broadway Date signed: July 14/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

05822

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months, 7 days

Hospital, Institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 2 months, 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1700 block Fleet St.

(If rural, give LOCATION)

2.(a) If veteran, name war: -

3. (a) FULL NAME: Peter Ostrowski

3. (b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	w	single

6.(b) Name of husband or wife: -

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 1, 1873

8. AGE: Years	Months	Days	If less than one day
74		20	hrs. min.

9. Birthplace: Poland (Town, county, and state)

10. Usual occupation: carpenter

11. Industry or business: unk.

FATHER

12. Name: George Ostrowski

13. Birthplace: Poland

MOTHER

14. Maiden name: Marianna Balakier

15. Birthplace: Poland

16. Informant: Hospital Records

Address: Catonsville 28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 23/47 (month) (day) (year)

Cemetery or crematory: Holy Cabary

Location: Baltimore

18. Funeral director: Fred W. Ozazewski

Address: 1930 Eastend Ave.

19. July 22 1947 (Date rec'd by registrar) A.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 21 1947 at 12:30a.m

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 14 1947 to July 21 1947 and that I last saw h... im alive on July 21 1947

	DURATION
Immediate cause of death: Hypostatic pneumonia	1 day
Due to: Hypertensive cardiovascular disease.	Indef.
Due to: Generalized arteriosclerosis	Indef.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D.
Catonsville 28, Md. M. D. or other

Address: Date signed 7/21/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

CERTIFICATE OF DEATH

05823

BC

Reg. Dist. No. .....

P

1. PLACE OF DEATH:
County Baltimore
City or town Relay
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2-9-46
Hospital, Institution, or street address where death occurred:
Relay Sanitarium Relay 27, Md.
How long in hospital or institution? 2-9-46

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County .....
City or town 6114 Smith Avenue
(If outside city or town limits, write RURAL and give nearest town)
Street No. Mt. Washington, Md.
(If rural, give LOCATION)
2.(a) If veteran, name war ---

3. (a) FULL NAME
Martha W. Owens

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife Sister; Mrs. Bessie O. Harper
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 8, 1871

8. AGE: Years	Months	Days	If less than one day
76	4	13	..... hrs. ..... min.

9. Birthplace Hay Market, Va. (Town, county, and state)
10. Usual occupation School teacher
11. Industry or business

FATHER
12. Name John S. Owens
13. Birthplace The Plains, Va.

MOTHER
14. Maiden name Mary M. Winter
15. Birthplace Clarksburg, W.Va.

16. Informant Mrs. Bessie O. Harper
Address 6114 Smith Ave., Mt. Washington Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 23/47 (month) (day) (year)
Cemetery or crematory Marshall
Location Marshall Va
18. Funeral director John O. Mitchell & Sons
Address 1900 Eutaw Place

19. 7/22 19 47 (Date rec'd by registrar) J. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 19 47, at 7 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 2-9-46 19 ..., to 7-21 19 47 and that I last saw her alive on 7-20- 19 47

Immediate cause of death	DURATION
Metastasis to left axilla right	
chest with collapse of right lung	20 mons.
Due to Carcinoma, left breast	14 yrs.
Due to	.....
Other conditions Psychoneurosis-anxiety state	20 mons

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma left breast (Breast amputation) Date of op. 14 yrs. ago.
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Lewis A. Tumby M.D.
M. D. or other
Address Relay Sanitarium Date signed July 21/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

8.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

CERTIFICATE OF DEATH

Reg. Dist. No. 05824

1. PLACE OF DEATH:
County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Hospital in the Pines 416 Fusting Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3 Wyndarest Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Anna E. Paine

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W.	Single

6.(b) Name of husband or wife —
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 13, 1858

8. AGE:

Years	Months	Days	If less than one day
88	6	21	..... hrs. ..... min.

9. Birthplace Md. (Town, county, and state)
10. Usual occupation None
11. Industry or business

FATHER
12. Name Robert Paine
13. Birthplace Md.

MOTHER
14. Maiden name Catharine Porter
15. Birthplace Md.

16. Informant Miss Dorothy P. Peregoy
Address 235 Mallow Hill Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 7/47. (month) (day) (year)
Cemetery or crematory Greenmount
Location Greenmount Ave. & Clives St.
18. Funeral director Harry H. Wittle
Address 4101 Edmondson Ave.

19. July 7 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4 1947, at 11:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 13 1942, to July 4 1947, and that I last saw h[illegible] alive on July 3 1947.

	DURATION
Immediate cause of death: Uremia	1 wk.
Due to: Chr. Interstitial Nephritis	(3)
Due to: Arteriosclerosis - senile degeneration	10 yr.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE William K. Gallagher M.D. M. D. or other
Address Catonsville 28, Md. Date signed 7-7-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 516

05825

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH:
County BALTIMORE
City or town SPARROWS PT. MD
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40
Hospital, Institution, or street address where death occurred:
708 E 5th
How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MD County Baltimore
City or town SPARROWS PT MD
(If outside city or town limits, write RURAL and give nearest town)
Street No. 708 E 5th St.
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3.(a) FULL NAME CHARLES H. PARKS

3.(b) Social Security Number 217-03-1597

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	C.	MARRIED

6.(b) Name of husband or wife MAUDE E.
6.(c) If alive, give age 43 years
7. Birth date of deceased (mo., day, yr.) MAR. 10 - 1875

8. AGE: Years	Months	Days	If less than one day
72			...hrs. ...min.

9. Birthplace LITTLETON N. C. (Town, county, and state)
10. Usual occupation MILLWRIGHT
11. Industry or business BETHLEHEM Steel Co
FATHER 12. Name WELDON PARKS
13. Birthplace N. C.
MOTHER 14. Maiden name CHARLOTTE ?
15. Birthplace
16. Informant MAUDE PARKS
Address 708 - E - St SPARROWS PT
17. Burial, cremation, or removal. Which? BURIAL Date thereof 7/9/47 (month) (day) (year)
Cemetery or crematory ARBUTUS MEM. PK.
Location ARBUTUS, MD
18. Funeral director Joseph L. Lockett
Address 1364 N. Central Ave.
19. July 8 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-5 1947, at 3 30 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1947 to 7-5 1947
and that I last saw h... alive on 7-4-47 1947

Immediate cause of death	DURATION
Carcinoma of Prostate	
Due to unknown	
Due to unknown	
Other conditions none	

(Include pregnancy within 3 months of death)

Major findings of operations none
Date of op.....
Autopsy results none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide none Date of.....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?).....
Means of injury Injured at work?

23. SIGNATURE William L. Johnson M. D. or other
Address 6395 Wardale Rd Date signed 7-8-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

05826 P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

BC Reg. Dist. No. 4 4

1. PLACE OF DEATH:
County Balto.
City or town Sparrows Point
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: #3 Open Hearth. B.S.Co.
How long in hospital or institution? 3½ yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother),
State Md. County
City or town Baltimore City #31.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 27 S. Dallas St.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME Andrew Peace

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M & L	Col	married

6.(b) Name of husband or wife
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) [illegible] 1886

8. AGE: Years	Months	Days	If less than one day
61			hrs. min.

9. Birthplace unknown (Town, county, and State)
10. Usual occupation Steel Worker
11. Industry or business Sparrows Point
FATHER 12. Name unknown
13. Birthplace " "
MOTHER 14. Maiden name unknown
15. Birthplace "
16. Informant Elsie Rokes
Address 27 S. Dallas St
17. Burial Date thereof July 28, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Mt. Calvary Cem.
Location Brooklyn Md
18. Funeral director Elroy O. Wilson
Address 1000 Baggetty ave
19. 7-28-47 [illegible]
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24 1947, at 11 50 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary occlusion	2 Minutes
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. McCarmine M.D.
Deputy Medical Examiner
(M.D. or other)
Address Dundalk Md Date signed 7-29-47.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

BC-05827 Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 364 Days

Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Ft. Howard, Maryland

How long in hospital or institution? 364 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 606 Archer Street
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3.(a) FULL NAME: ROBERT PEARSON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Hilda Pearson

6.(c) If alive, give age: 46 years

7. Birth date of deceased (mo., day, yr.): 8-24-92

8. AGE: Years	Months	Days	If less than one day
54	9	4	....hrs. ....min.

9. Birthplace: Emporia, Va.
(Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business:

FATHER
12. Name: Robert Pearson
13. Birthplace: Emporia, Va.

MOTHER
14. Maiden name: Martha Londay
15. Birthplace: Emporia, Va.

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Ft. Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-1-1947 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery
Location: Baltimore, Md.

18. Funeral director: Katie Williams
Address: 322 N. Schroeder St., Balto., Md.

19. July 30 1947 (Date rec'd by registrar) A. W. Fedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 28, 1947 at 11:15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 29, 1946 to July 28, 1947 and that I last saw him alive on July 28, 1947

Immediate cause of death	DURATION
TUBERCULOSIS, CHRONIC PULMONARY FAR ADVANCED	unknown
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ....Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Glenn, MD
M. D. or other

Address: V.A.H. FORT HOWARD, MD. Date signed: 7-28-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

05829

CERTIFICATE OF DEATH

Reg. Dist. No.

P

1. PLACE OF DEATH:

County: Balt.

City or town: Hilton Dale (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Balt.

City or town: Hilton Dale (If outside city or town limits, write RURAL and give nearest town)

Street No.: 607 Hilton Rd. Towson (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Henry J. Peitz

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W.	M

6.(b) Name of husband or wife: Katherine L. Peitz

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 25, 1885

8. AGE: Years: 62 Months: 5 Days: 6 If less than one day: ..... hrs. ..... min.

9. Birthplace: Baltimore (Town, county, and state) Md.

10. Usual occupation: Retired

11. Industry or business:

FATHER — 12. Name: Conrad Peitz

13. Birthplace: Md.

MOTHER — 14. Maiden name: Augusta Fink

15. Birthplace: Germany

16. Informant: Katherine L. Peitz

Address: 607 Hilton Rd.

17. Burial (Burial, cremation, or removal? Which?) Date thereof: Aug 4-47 (month) (day) (year)

Cemetery or crematory: Parkwood Mem.

Location: Taylor Ave.

18. Funeral director: John A. McGraw

Address: 4201 Greenmount Ave

19. 8-1 (Date rec'd by registrar) 19 47 A. W. Edwards M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 31 19 47 at 12:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-16- 19 47 to 7/31 19 47 and that I last saw him alive on July 31 19 47

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Laurence C. Tosh M.D. M. D. or other

Address: 6805 York Road Date signed: 7/31/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05828

Reg. Diat. No. 238

1. PLACE OF DEATH:
County Baltimore
City or town Towson 4, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 Months.
Hospital, institution, or street address where death occurred:
Eudowood Sanatorium, Towson 4, Md.
How long in hospital or institution? 17 Months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Balto City
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3023 Presbury Ave. (If rural, give LOCATION)
2.(a) If veteran, name war W.W. I

3.(a) FULL NAME William P. Illinger (WILLIAM NELSON PHILLINGER)

3.(b) Social Security Number 215-05-2675

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male.	White	DIVORCED

6.(b) Name of husband or wife — Formerly Margaret Phillips

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 28, 1893 (6-28-1893)

8. AGE: Years	Months	Days	If less than one day
54	0	8	hrs. min.

9. Birthplace Maryland. (Town, county, and state)
10. Usual occupation Chauffeur
11. Industry or business —

FATHER
12. Name John P. Illinger
13. Birthplace Maryland.

MOTHER
14. Maiden name Georgiana Shipley
15. Birthplace Maryland.

16. Informant Personal History- Hospital Records
Address Towson Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July- 9-47 (month) (day) (year)
Cemetery or crematory Spring Hill Cemetery
Location Sykesville Md
18. Funeral director Stewart Mortuary Company
Address 108 W. North Ave.

19. 7-7-1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6 1947 at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 14 1946 to July 5 1947 and that I last saw him alive on July 5 1947

Immediate cause of death	DURATION
Pulmonary Tb.	2 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) — (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE Wm. Bridges M. D. or other
Address Towson 4, Maryland Date signed

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

05830

CERTIFICATE OF DEATH

Reg. Diat. No. .....

1. PLACE OF DEATH:

County ..... Balto

City or town ..... White Marsh

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred:

Old Phila. Rd.

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State ..... Md ..... County ..... Balto.

City or town ..... White Marsh

(If outside city or town limits, write RURAL and give nearest town)

Street No. ..... Old Phila. Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME Clarence Franklin Ports

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, ~~widowed, or divorced~~
Male	White	Married

6.(b) Name of ~~husband~~ or wife Marie E. Ports

8.(c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) Aug 2nd 1886

8. AGE: Years	Months	Days	If less than one day
60	11	7	..... hrs. ..... min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual occupation Bus Driver

11. Industry or business Rosedale Bus Line

FATHER 12. Name Unknown Ports

13. Birthplace "

MOTHER 14. Maiden name "

15. Birthplace "

16. Informant Marie E. Ports

Address Phila Rd. White Marsh Md

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 7/12/47 (month) (day) (year)

Cemetery or ~~crematory~~ Cathedral

Location Balto. Md.

18. Funeral director William Cook Inc.

Address 1217 St. Paul St.

19. 7-11 1947 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9 1947, at 2:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1947, to July 9 1947 and that I last saw h~~im~~ alive on July 9 1947

Immediate cause of death	DURATION
Coronary Thrombosis	Sudden
Due to Arterio-Sclerotic Cardio vascular disease	
Due to	
Other conditions Peri-Carditis	2 wks

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Geo. M. Baumgardner M. D. or other

Address Balto 6 Md. Date signed 7-9-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

05831

Reg. Diat. No. 44

1. PLACE OF DEATH:
County: Balto.
City or town: Middle River
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Martin Plant "D" Bldg.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County:
City or town: Dundalk.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1775 Lynch Rd
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Marion Powell

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married.

6.(b) Name of husband or wife: Mary E. Millar.
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan 13/1901

8. AGE: Years 46 | Months 5 | Days 18 | If less than one day: hrs. min.

9. Birthplace: Alabama
(Town, county, and state)

10. Usual occupation: Air Craft Mech.

11. Industry or business: Glen L. Martin

FATHER
12. Name: Frank C.
13. Birthplace: Georgia

MOTHER
14. Maiden name: not known
15. Birthplace: " "

16. Informant: Wife
Address: 1775 Lynch Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/5/47 (month) (day) (year)
Cemetery or crematory: Mt. Carmel
Location: O'Donnell St.

18. Funeral director: Clarence F. Hoffmann
Address: 1639 Broadway.

19. 7/2 19 47 (Date rec'd by registrar) A. H. Hedrick a E S Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 1 1947 at 9A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: M. McCarmine M.D.
Deputy Medical Examiner Balto Co. M. D. or other
Address: Dundalk Md. Date signed 7/7/47.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

06474

CERTIFICATE OF DEATH

Reg. Dist. No. 35

1. PLACE OF DEATH:
County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Downs Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Charles G. Price

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Emma
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov 3 1858

8. AGE: Years: 88 | Months: 8 | Days: 18 | If less than one day: hrs. min.

9. Birthplace: Talbot Co Md (Town, county, and state)

10. Usual occupation: Capenter Retired

11. Industry or business: U. S. R.

FATHER
12. Name: John Price
13. Birthplace: Md

MOTHER
14. Maiden name: Whitmore
15. Birthplace: Md

16. Informant: John A. Price
Address: Towson Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 7/24/47 (month) (day) (year)
Cemetery or crematory: Baltimore
Location: Baltimore Md

18. Funeral director: Wilmer Bortner Jr
Address: 1217 E Fayette St

19. July 23 1947 A. W. Herrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 21 1947, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1, 1943, to July 21 1947
and that I last saw h alive on July 19 1947

Immediate cause of death	DURATION
Coronary Thrombosis	1 day
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Wilmer Bortner M.D.
M. D. or other
Address: White Hall Md. Date signed: July 21 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

05832 37

Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH

County: Balto Co.

City or town: Sparks

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Sparks

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Evan Emory Preed

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	married

6.(b) Name of husband or wife: Mary Louise Carlisle Preed

6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): July 17, 1878

8. AGE: Years 68 | Months 11 | Days 14 | If less than one day ... hrs. ... min.

9. Birthplace: Sparks Balto Co. Md (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Farmg

FATHER 12. Name: Emory Preed

FATHER 13. Birthplace: Balto. Co. Md.

MOTHER 14. Maiden name: Ellen Wheeler [redacted]

MOTHER 15. Birthplace: Balto Co. Md.

16. Informant: Thomas Preed

Address: Monkton, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-3-47 (month) (day) (year)

Cemetery or crematory: Jessops Methodist

Location: Sparks

18. Funeral director: J. Scott Brooks

Address: Sparks, Md.

19. July 2, 1947 (Date rec'd by registrar) Wilmer C. Ensor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 1 1947 at 1 O.D. M

I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 1945 to July 1 1947

and that I last saw h... alive on 6/29 1947

Immediate cause of death	DURATION
Coronary Thrombosis	Sudden
Due to: Myocarditis	2 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Wilmer C. Ensor M.D. M. D. or other

Address: Cockeysville Md Date signed 7/4/47

RECEIVED
JUL 8 1947
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05833

172

Reg. Dist. No. 44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 2-49-15M

1. PLACE OF DEATH

County: Balto.

City or town: Sparrows Point.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address (where death occurred): Patapsco River ft Slip Yard.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Essex

(If outside city or town limits, write RURAL and give nearest town)

Street No. 835 E Chesaco Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Robert Eugene Reynolds.

3. (b) Social Security Number --

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single.

6.(b) Name of husband or wife: -

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 20, 1940

8. AGE:

Years	Months	Days	If less than one day
7	6	0	..... hrs. ..... min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER

12. Name: Eugene Arthur Reynolds

13. Birthplace: Virginia

MOTHER

14. Maiden name: Annabelle Heinefield

15. Birthplace: Baltimore, Md.

16. Informant: Mr. Eugene A. Reynolds

Address: 835 Chesaco Ave., Essex, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/24/47 (month) (day) (year)

Cemetery or crematory: Parkwood Cem.

Location: Balto., Md.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19. 7-23 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1947 at 7:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death: Drowning (accidental)

DURATION

Due to: 0

Due to: Recovered 7/22/47 7 A.M.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide? Accident Date of 7/20/47

Where did injury occur? Sparrows Pt. Balto. Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Public Place

Means of injury: Fell from boat (drowned) Injury at work? No

23. SIGNATURE: J. M. Barnum M.D. Deputy Medical Examiner M.D. or other

Address: Glendale, Md. Date signed 7-22-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

05834

Reg. Dist. No. 60

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15

1. PLACE OF DEATH:
County Baltimore
City or town 304 Newburg Ave. Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town 304 Newburg Ave Catonsville Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 304 Newburg ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME John Roleder

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Caroline Roeder
6.(c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) February 7, 1867.

8. AGE: Years	Months	Days	If less than one day
80	4	27	...hrs. ...min.

9. Birthplace Germany (Town, county, and state)
10. Usual occupation Tailor
11. Industry or business Tailor
FATHER 12. Name Jacob Roeder
FATHER 13. Birthplace Germany
MOTHER 14. Maiden name Unknown
MOTHER 15. Birthplace Unknown
16. Informant Mrs. Caroline Roeder
Address 304 Newburg Ave., Catonsville Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/1/47 (month) (day) (year)
Cemetery or crematory Western Cemetery
Location Baltimore, Md.
18. Funeral director Easton Sons
Address Ellicott City, Md.
19. 7-6 1947 (Date rec'd by registrar) Harry W. Miller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4 1947, at 2 14 M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1932 to July 4 1947
and that I last saw him alive on July 3 1947

	DURATION
Immediate cause of death Parkinsons Disease	15 yrs
Due to Myocardial degeneration	1 yr
Due to Senile Arteriosclerosis	5 yrs
Other conditions Decubitus Ulcers, sacrum	6 mo.

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE R. B. Brumbaugh M. D. or other
Address Elkridge Md. Date signed 7/6/47

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BUREAU OF R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a 05835

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
County Baltimore
City or town Catonsville - Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? one year
Hospital, institution, or street address where death occurred
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Catonsville - Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William H Rohrbaugh.

3.(b) Social Security Number —

4. Sex M
5. Color or race W
6.(a) Single, married, widowed, or divorced married
6.(b) Name of ~~husband~~ or wife Frances Rohrbaugh
6.(c) If alive, give age 65 years
7. Birth date of deceased (mo., day, yr.) April 19 - 1877
8. AGE: Years 70 Months 2 Days 13 If less than one day ..... hrs. ..... min.
9. Birthplace Maryland
(Town, county, and state)
10. Usual occupation Dentist
11. Industry or business

FATHER
12. Name Henry Rohrbaugh
13. Birthplace Ind

MOTHER
14. Maiden name Annie Fowble
15. Birthplace Md

16. Informant Miss Margaret Rohrbaugh
Address 2103 Laiden Ave, Baltimore
17. Burial Date thereof July 5/47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Emory
Location Carroll Co Md
18. Funeral director Edw C Tipton
Address Hampstead Md
19. July 2 1947 Harry W. Miller
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2, 1947, at 9:50 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 5, 1947, to July 2, 1947
and that I last saw him alive on July 2, 1947

	DURATION
Immediate cause of death Cerebral Hemorrhage	2 days.
Due to Arteriosclerosis	3 yrs.
Due to	
Other conditions Cerebral Sclerosis	3 Mos.

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Albert G Fitzgerald M.D. or other
Address 1613 E. North Ave Date signed 7-3-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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JUL 8 1947
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

C6475

CERTIFICATE OF DEATH

Reg. Dist. No. 35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Rural near White Hall

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 74 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Rural near White Hall

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Stablersville.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Harriett Lavina Rosier

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married.

6.(b) Name of husband or wife: George A. Rosier

6.(c) If alive, give age: 79 years

7. Birth date of deceased (mo., day, yr.): December 23, 1871

8. AGE: Years: 75 Months: 7 Days: 7 If less than one day: ...hrs. ...min.

9. Birthplace: Baltimore Co. Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own home.

FATHER 12. Name: Ezekial Bailey

13. Birthplace: Md.

MOTHER 14. Maiden name: Caroline Hollingshead.

15. Birthplace: Md

16. Informant: Mrs. Ernest L. Grubb.

Address: White Hall, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: August 2, 1947 (month) (day) (year)

Cemetery or crematory: Stablersville Cemetery

Location: Parkton, Md. R.D.

18. Funeral director: Jacob Hartenstein

Address: New Freedom, Pa.

19. Aug 1 1947 (Date rec'd by registrar) Charles L. Fuselton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 30 1947, at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1938, to July 30 1947

and that I last saw h... alive on July 29 1947

Immediate cause of death: Chronic myocarditis

Due to:

Due to:

Other conditions: Hypertension. Diabetes mellitus

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: C. M. Frances M. D. or other

Address: Parkton, Md. Date signed: 7/31/47

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AUG 28 1947
BUREAU OF S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

05836 44

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS/A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Chase

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Chase

(If outside city or town limits, write RURAL and give nearest town)

Street No.: West Twin River Beach Rd.

(If rurol, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: John A Roth

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Catherine Roth

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 9th, 1876

8. AGE: Years	Months	Days	If less than one day
70	8	21	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Collector

11. Industry or business

FATHER — 12. Name: Joseph Roth

13. Birthplace

MOTHER — 14. Maiden name: Catherine Simon

15. Birthplace

16. Informant: Mrs. John A. Roth

Address: West Twin River Beach Rd.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 7/24/47 (month) (day) (year)

Cemetery or crematory: Ebenezer

Location: Chase, Md.

18. Funeral director: Lassahn Funeral Home

Address: 7401 Belair Rd.

19. 7/22/47 (Date rec'd by registrar) 19 John L. Connelly Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH: July 21st 1947 at 6:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 1947 to July 21 1947 and that I last saw h[illegible] alive on July 21 1947

	DURATION
Immediate cause of death: Coronary Thrombosis	Sudden
Due to: arteriosclerotic Cardio-Vascular disease	
Due to:	
Other conditions: Osteo-arthritis	15 yrs

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

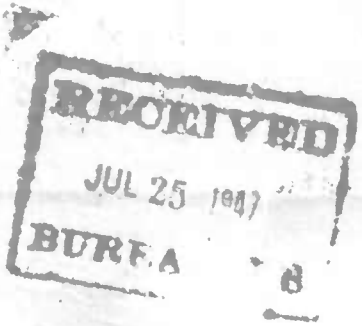
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Geo M. Baumgardner M. D. or other

Address: Balto 6 Md Date signed: 7-21-47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(39)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83b 05837

Reg. Diat. No. 44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore Maryland
City or town: Essex
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: c/o Walnut Grove, Balto. City
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 2629 E. Biddle St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: John Benedict Ruddy

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Henrietta L. Ruddy
6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): Feb-9-1894

8. AGE: Years	Months	Days	If less than one day
53	5	9	hrs. min.

9. Birthplace: Balto. Md. (Town, county, and state)
10. Usual occupation: asst. Manager Standard
11. Industry or business: Oil Co.

FATHER
12. Name: Christopher Ruddy
13. Birthplace: Austria

MOTHER
14. Maiden name: Thekla Faumman
15. Birthplace: Germany

16. Informant: Henrietta L. Ruddy
Address: 2629 E. Biddle St

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 21-47 (month) (day) (year)
Cemetery or crematory: Loudenner
Location: Balto. Md.

18. Funeral director: John C. Miller Inc.
Address: 2435 E. Oliver St.

19. July 19 1947 (Date rec'd by registrar) Wm. G. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 18 July 1947 at 10 a. m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 11 July 1947 to 18 July 1947 and that I last saw him alive on 17 July 1947

	DURATION
Immediate cause of death: Broncho pneumonia	3 days
Due to: Cerebral Thrombosis & hemiplegia.	7 days
Due to:	
Other conditions: Parkinsons disease Following encephalitis	8 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Maxwell H. Mund M.D.
M. D. or other
Address: 417 S. Eastern Ave. Date signed: 7-19-47

RECEIVED
JUL 25 1947
BUREAU OF R

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05838

93d

Reg. Dist. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: 6 Mt De Sales Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6 Mt De Sales Rd
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Anita A Puppert

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Matthias L.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 18 1885

8. AGE: Years	Months	Days	If less than one day
62	3	21	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Thos J O'Neill
13. Birthplace: Md
MOTHER 14. Maiden name: Anna Cooney
15. Birthplace: Md
16. Informant: Matthias L Puppert
Address: 6 Mt De Sales Rd
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-12-47 (month) (day) (year)
Cemetery or crematory: Meadowridge
Location: Elkridge Md
18. Funeral director: Jesse G Stanley
Address: Catonsville Md
19. 7-11- 1947 (Date rec'd by registrar) Harry St Mullen Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 9 1947, at 10:45 P.M.
21. I CERTIFY that death occurred on the date above stated, that I attended deceased from July 1946 to July 9 1947
and that I last saw her alive on July 9 1947

Immediate cause of death	DURATION
Cardiac Asthenia	2d
Coronary Thrombosis	1 minute
Due to Carcinoma Pancreas	10 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: no Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Ed Coon M. D. or other
Address: 1202 St Paul St Date signed: 9/10/47

RECEIVED
JUL 12 1947

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

183 Registered No. 30

C6476

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Dickey Mill- Oella, Md.
(b) Street address Race -Patapsco River- (County)
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. 209 Shady Nook Court. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ANNE ELIZABETH RYAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: 0

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/30/32

8. AGE: Years 14 | Months | Days | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Student

11. Industry or business High School

FATHER
12. Name Wm J Ryan
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Kelly
15. Birthplace Ala.

16 (a) Informant Elizabeth Kelly
(b) Address 209 Shady Nook Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 18 1947 (month) (day) (year)
(c) Cemetery or crematory Loyola Park
Location Balto Cty Md

18 (a) Funeral director Edw J MacNabb
(b) Address Catonsville Md.

19 (a) 7-17 1947 (b) Date received by registrar) R. W. Hoffman Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15, 1947, at 10 a. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Found 7-15-47 8.40 a. M.
(b) Where did injury occur? Dickey Mills, Oella, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Found drowned

23. Signature George L. Merrill M.D. Medical Examiner.
Date signed 7-15-47

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age

VS A15 9-45-15M

Dr. Ford
20 E. Preston St

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 55e

05839

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:
County: Baltimore
City or town: Dickeysville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Home
Hospital, institution, or street address where death occurred: -
How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Dickeysville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Helen W. Sangston

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Col. Lawrence P. Sangston
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 18, 1912

8. AGE: Years	Months	Days	If less than one day
35			..... hrs. ..... min.

9. Birthplace: Des Moines, Iowa (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: -

FATHER
12. Name: John White.
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Nettie Shertzer
15. Birthplace: Maryland

16. Informant: Col. Laurence Sangston
Address: 2402 W. Forrest Park Avenue

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 19 1947 (month) (day) (year)
Cemetery or crematory: Mt. Zion, Harford County
Location: Maryland

18. Funeral director: Wm. Cook, Inc.
Address: 1217 St. Paul Street

19. 7/18 1947 (Date rec'd by registrar) A.W. Hedrick Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 17th 1947 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 1946 to July 17 1947 and that I last saw her alive on July 16 1947

Immediate cause of death	DURATION
Lymphosarcoma. Generalized	9 Mos -
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Gastric Lymphosarcoma - Women's Hospital - Date of op. Jan. 1, 1947

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: -
Accident, suicide, or homicide: Date of ~~June 1947~~
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Wm. Webster Ford M. D. or other
Address: 20 E. Preston St. Date signed: 7/18/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

05840

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 days

Hospital, institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 943 Wilmot Court
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME

James Sapp

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Sally Lowry

6.(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): 1885?

8. AGE: Years	Months	Days	If less than one day
62	?	?	...hrs. ...min.

9. Birthplace: California
(Town, county, and state)

10. Usual occupation: Ironworker

11. Industry or business: Structural ironwork

FATHER
12. Name: ?
13. Birthplace: ?

MOTHER
14. Maiden name: ?
15. Birthplace: ?

16. Informant: Hospital records

Address: Catonsville-28, Maryland

17. Burial, cremation, or removal. Which?: Burial Date thereof: 7/9/47 (month) (day) (year)

Cemetery or crematory: Maryland Memorial Park

Location: Baltimore Co. Md.

18. Funeral director: Wilson Bros Inc

Address: 1317 E Pratt St

19. 7-9-47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 6 1947, at 7:55a M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 21- 1947, to July 6 1947 and that I last saw h...im alive on July 6 1947

Immediate cause of death	DURATION
Chronic myocarditis	indefinite
Due to: Paralysis agitans	"
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D. M. D. or other

Address: Catonsville-28, Md. Date signed: 7-7-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct one is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Gordy

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

47d

6477 P

Reg. Dist. No. 38

1. PLACE OF DEATH:
County Stoneleigh Baltimore
City or town Baltimore Stoneleigh
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
7014 Kenleigh Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Stoneleigh Baltimore
City or town Baltimore Stoneleigh
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7014 Kenleigh Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Frank H. Schaffer

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Mary Schaffer
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 10, 1871

8. AGE: Years	Months	Days	If less than one day
75	10	14	..... hrs. ..... min.

9. Birthplace Youngstown, Ohio (Town, county, and state)
10. Usual occupation Roughers on Rolls - 25 yrs
11. Industry or business American Steel & Wire Co.
FATHER 12. Name George Schaffer
13. Birthplace Germany
MOTHER 14. Maiden name Catherine Revel
15. Birthplace Germany
16. Informant Mrs. Mary Schaffer
Address 7014 Kenleigh Road
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/26/47 (month) (day) (year)
Cemetery or crematory Parkwood
Location Baltimore
18. Funeral director Leonard J. Ruck
Address 5305 Harford Road, 14
19. 7-25-47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24th, 1947 at 5 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1st 1947, to July 24th 1947 and that I last saw h.. alive on July 24th 1947

Immediate cause of death	DURATION
Carcinoma Right Lung	1 year
Due to	
Due to	
Other conditions Chronic myocarditis	4 years

(Include pregnancy within 3 months of death)

Major findings of operations none Date of op.
Autopsy results none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide none Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury none Injured at work?

23. SIGNATURE L. L. Gordy M.D. M. D. or other
Address 5106 Harford Rd Date signed 7-24-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 172

CERTIFICATE OF DEATH

Reg. Diat. No. 0761

1. PLACE OF DEATH:
County: Baltimore
City or town: Edgemere
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 121 Baltimore Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Maurice S. Schlimme

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 11, 1916

8. AGE: Years	Months	Days	If less than one day
31	0	16	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Photographer
11. Industry or business: Edgewood Arsenal
FATHER 12. Name: Leo C. Schlimme
13. Birthplace: Pa.
MOTHER 14. Maiden name: Ruth E. Stafford
15. Birthplace: New York
16. Informant: Donald W. Schlimme
Address: 121 Baltimore Ave., Dundalk
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 30, 1947 (month) (day) (year)
Cemetery or crematory: Oak Lawn
Location: Eastern Blvd.
18. Funeral director: Roland L. Fuhrer
Address: 2112 Dundalk Ave.
19. 7/30/47 19.. W. M. Gardner Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 27, 1947, at 5:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19.. to ..... 19..
and that I last saw h..... alive on ..... 19..

Immediate cause of death	DURATION
(1) DROWNING	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 7-27-47
Where did injury occur? Dundalk Baltimore Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Public Place
Means of injury: Fell from boat in water Injured at work? No

23. SIGNATURE: [illegible] M.D. or other
Address: Dundalk Md Date signed 7/29/47

RECEIVED
AUG 31 1967
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

43d 05842

Reg. Dist. No. 42

1. PLACE OF DEATH:
County: Balto
City or town: Balto Highlands
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution or street address where death occurred: Vernon Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto
City or town: Balto Highlands
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Vernon Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Frederick Lawrence (Schwallenberg)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Unknown
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Unknown (About 1873)

8. AGE: Years	Months	Days	If less than one day
74	?	?	..... hrs. ..... min.

9. Birthplace: New York (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business

FATHER
12. Name: William Schwallenberg
13. Birthplace: Germany

MOTHER
14. Maiden name: Louise Kerchner
15. Birthplace: Germany

16. Informant: Mrs. Minnie Ritzheimer
Address: 185 Bay View Ave., Amityville, L.I., N.Y.

17. Removal (Burial, cremation, or removal. Which?) Date thereof July 17, 1947 (month) (day) (year)
Cemetery or crematory: Lutheran Cemetery
Location: Middle Village, Long Island, N. Y.
18. Funeral director: [illegible] Donovan
Address: 4510 Liberty Heights Ave.

19. July 16 1947 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 15 19 47 at [illegible] M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary occlusion	
Due to	
Due to Cardiovascular disease	
Other conditions Sudden death	
(Include pregnancy within 3 months of death)	

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: [illegible] Kerkhoff Eutaw Balto M. D. or other
Address: 1010 Leeds Ave., Arbutus Date signed: 7-16-47

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUL 21 1947
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH 93d

05843

Reg. Dist. No. 33

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Baltimore
City or town: Owings Mills
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Owings Mills
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: EDGAR B. SHIPLEY

3.(b) Social Security Number: 218-10-8432

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of ~~husband or~~ wife: Alice Edna Shipley deceased

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 15, 1868

8. AGE: Years 78 | Months 8 | Days 18 | If less than one day: hrs. min.

9. Birthplace: Carroll Co., Maryland
(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business

FATHER
12. Name: Basil Shipley
13. Birthplace: Maryland

MOTHER
14. Maiden name: Margaret Harps
15. Birthplace: Maryland

16. Informant: Mrs. James Orton Dorsey
Address: Owings Mills, Md.

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 7-6-47 (month) (day) (year)
Cemetery ~~or crematory~~: Morgan Chapel
Location: Woodbine, Carroll Co., Md.

18. Funeral director: C. M. Waltz
Address: Winfield, Md.

19. July 5 19 47 (Date rec'd by registrar) Mary B. E. Linn Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7/3/47 19 at 8:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/15/47 19 to 7/3/47 19 and that I last saw h[illegible] M alive on 7/2/47 19

Immediate cause of death	DURATION
Coronary Thrombosis	1 week
Due to Arteriosclerosis	years
Due to Myocarditis	2 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Reisterstown Date signed 7/4/47

RECEIVED
JUL 9 1947
BUREAU V. M.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

05844

Reg. Diat. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville 28, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 yrs., 2 mos., 18 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 9 yrs., 2 mos., 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 3310 Parkington Avenue (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

T. Herbert Slade

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 29, 1884

8. AGE: Years	Months	Days	If less than one day
63	3	22	hrs. min.

9. Birthplace: Maryland, Baltimore (Town, county, and state)

10. Usual occupation: None

11. Industry or business: None

FATHER 12. Name: Thomas T. Slade

13. Birthplace: Maryland, Baltimore County

MOTHER 14. Maiden name: Emma Amelia Shirley

15. Birthplace: Maryland, Baltimore County

16. Informant: Mrs. Blanche Michael ~~Hospital Records~~

Address: ~~Catonsville 28, Maryland~~ 3310 Parkington Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 24, 1947 (month) (day) (year)

Cemetery or crematory: Druid Ridge Cemetery

Location: Pikesville, Md.

18. Funeral director: C. Wells Lamoreau

Address: 4510 Liberty Heights Ave.

19. July 22 19 47 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 21, 1947, at 11:25a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h... alive on ..... 19.....

Immediate cause of death ..... DURATION

Burns Pneumonia

Due to: Hypertension Cardio Vascular Disease

Due to: Death was not actually due to injury or burns.

Other conditions: Burned by hot water bottle on foot (bottle suspected)

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of: June 11-47

Where did injury occur? Catonsville (City or town) Baltimore (County) Md. (State)

Injured at home, farm, industry, public place (where?) Burned foot by hot water bottle at hospital

Means of injury: Burned foot by hot water bottle Injured at work?

23. SIGNATURE: Geo. L. McIlvaine Dept. Med Examr Balto Co. M. D. or other

Address: 1010 Leeds Ave Date signed: 7-31-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 130

05845

CERTIFICATE OF DEATH

Reg. Diat. No. 44

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 69 days
Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp. Fort Howard, Md.
How long in hospital or institution? 69 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3301 Paine St.
(If rural, give LOCATION)
2.(a) If veteran, name war: WW I ✓

3.(a) FULL NAME
GEORGE L. SLIMMER

3.(b) Social Security Number
215-07-6445

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Myrtle Slimmer
6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): October 1,1900

8. AGE: Years	Months	Days	If less than one day
46	9	10	....hrs. ....min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)
10. Usual occupation: Textile Worker
11. Industry or business

FATHER
12. Name: Samuel Slimmer, deceased
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden name: Carrie Jeffrey, deceased
15. Birthplace: Baltimore, Md.

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Fort Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 15-1947 (month) (day) (year)
Cemetery or crematory: National Cemetery
Location: Baltimore, Maryland

18. Funeral director: Burgee Funeral Home
Address: 3631 Falls Road, Baltimore, Md.

19. 7/14 1947 A. W. Hedrick Jr. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 11 1947 at 3:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 3 1947 to July 11 1947 and that I last saw him alive on July 11 1947

Immediate cause of death	DURATION
Sub Acute Nephritis	3 mos.
Due to: Cause Unknown (8/27/47-V.S.)	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Vincent F. Sciullo M. D. or other
V.F. Sciullo, M.D.
Address: VEts.Adm. Hosp.Ft.Howard,Md. Date signed: 7/11/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06478 Q

93d BW

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 months

Hospital, institution, or street address where death occurred: Spring Grove State Hospital

How long in hospital or institution? 21 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City

(If outside city or town limits, write RURAL and give nearest town)

Street No. 715 1/2 W. Franklin St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Elsie Marie Smith

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: Washington Smith

6.(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): December 25, 1882

8. AGE: Years 64 | Months 6 | Days 25 | If less than one day: hrs. min.

9. Birthplace: Middletown, Delaware

(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business:

FATHER — 12. Name: Edward Plummer

13. Birthplace: Md.

MOTHER — 14. Maiden name: Eliza Prettyman

15. Birthplace: Md.

16. Informant: Mr. Washington Smith

Address: 715 1/2 W. Franklin St.

17. Removal & Burial (Burial, cremation, or removal. Which?) Date thereof July 22/47 (month) (day) (year)

Cemetery or crematory: Mistley Lehigh Mem

Location: Rock Hall Md

18. Funeral director: Philip Stauffer Sons

Address: 2024 Orleans St

19. July 21 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 19, 1947, at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 25 1945 to July 19, 1947

and that I last saw h.. alive on July 19, 1947

	DURATION
Immediate cause of death: Coronary Thrombosis	5 minutes
Due to: Coronary Artery Disease	1 yrs.
Due to: Hypertension cardio-vascular Disease	30 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Isador Lurie, M. D.

Address: Spring Grove State Hosp. M. D. or other

Date signed: 7/19/47

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information called for. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

06475

CERTIFICATE OF DEATH

Reg. Diat. No. 41

1. PLACE OF DEATH:

County: Balto.

City or town: Turners Sta (Glendale)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: 125 Sollers Pt Rd.

How long in hospital or institution? 20 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Same County:

City or town:
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME Samuel Smith,

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 1. 1870

8. AGE:

Years	Months	Days	If less than one day
77	7	29	hrs. min.

9. Birthplace: East Co. Va.
(Town, county, and state)

10. Usual occupation: unemployed

11. Industry or business

FATHER — 12. Name: Horace Smith

FATHER — 13. Birthplace: Va

MOTHER — 14. Maiden name: Bettie Hutchinson

MOTHER — 15. Birthplace: Va

16. Informant: Jesse Smith

Address: 2705 Emerson St.

17. B. (Burial, cremation, or removal. Which?) Date thereof 8-3-47 (month) (day) (year)

Cemetery or crematory: Arbutus Mem. Park

Location: Balto. Co.

18. Funeral director: Samuel W. Sullivan Jr

Address: 1811 N. Arlington Ave

19. 7-31 19.4 (Date rec'd by registrar) A A Redmiles Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 30 1947, at 12.15 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: M Learning M. D.
Deputy medical Examiner M. D., or other

Address: Baltimore Md. Date signed: 7/30/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

[redacted] HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95C

Registered No. 05846

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:
(a) Baltimore ~~City~~, Maryland
(b) Street address 806 Mace Ave. Essex.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 806 Mace Ave. Essex.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME THELMA M. SOUL

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife Frank L.
6 (c) If alive, give age 30 years

7. Birth date of deceased (mo., day, yr.) June 14-1912

8. AGE: Years	Months	Days	If less than one day
35	1	1	hr. min.

9. Birthplace Butler Md
(Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business At Home

FATHER
12. Name John Theis
13. Birthplace Ludowberg

MOTHER
14. Maiden Name Unknown
15. Birthplace Altoona Pa.

16 (a) Informant Frank L. Soul
(b) Address 806 Mace Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/19/47 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location O'Donnell St.

18 (a) Funeral director John B. Comelly
(b) Address 418 Eastern Ave.

19 (a) 7/17/47 (Date rec'd by registrar) (b) John B Comelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15, 1947, at 5.10P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute pulmonary edema:
underlying cause was probably
Due to Cardiac, but this could not
be proved - body was already
embalmed at autopsy
Other Conditions [491.0 (477.4)]
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Geo. L. Merrill M.D.
Medical Examiner.
Date signed 7-16-47

VS 151

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46e 05847

Reg. Diat. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Balto. Co.

City or town Catonsville Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 mo.

Hospital, Institution, or street address where death occurred:
208 Hilton

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Balto. Co.

City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)

Street No. 208 Hilton
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Xenia Carr Sparks

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife: Thomas R Sparks

6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): Dec 3 1882

8. AGE: Years	Months	Days	If less than one day
64			hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: housewife

FATHER — 12. Name: Rosby W Carr

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Anne M. Roberts

MOTHER — 15. Birthplace: Maryland

18. Informant: Thomas R Sparks

Address: 208 Hilton Ave

17. Burial (Burial, cremation, or removal? Which?) Date thereof 7/21/47 (month) (day) (year)

Cemetery or crematory: London Park

Location: Balto Co Md

18. Funeral director: Chas S Mac Nabb

Address: Catonsville Md

19. 7-21 19 47 (Date rec'd by registrar) Harry D. Miller Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 18 July 19 47 at 7 30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 6 19 47 to July 19 19 47 and that I last saw h... E.R. alive on July 19 19 47

	DURATION
Immediate cause of death: Intestinal obstruction	2 days
Due to: Peritoneal Carcinomatosis	3 mos
Due to: Carcinoma colon	Unknown
Other conditions: Cachexia	

(Include pregnancy within 3 months of death)

Major findings of operation: Ca colon Date of op. Unknown

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Stephen Lee Magness MD
M. D. or other

Address Catonsville 28 Date signed July 19 '47

Dr. Howell

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a 05848

CERTIFICATE OF DEATH

Reg. Diat. No. 30

1. PLACE OF DEATH

County: Baltimore

City or town: Rural Catonsville, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 8 Mount Ridge Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Rural Catonsville, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 8 Mount Ridge Road
(If rural, give LOCATION)

2.(a) If veteran, name war: Yes #1

3.(a) FULL NAME: Raymond A. Staples

3.(b) Social Security Number

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Henrietta J. Staples

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 2, 1891

8. AGE: Years: 56 Months: 0 Days: 24 If less than one day: ..... hrs. ..... min.

9. Birthplace: Massachusetts (Town, county, and state)

10. Usual occupation: Clerk - Post Office

11. Industry or business

FATHER
12. Name: Harry Staples
13. Birthplace: Massachusetts

MOTHER
14. Maiden name: Nellie Unknown
15. Birthplace: Massachusetts

16. Informant: Henrietta J. Staples
Address: 8 Mount Ridge Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/28/47 (month) (day) (year)

Cemetery or crematory: Loudon Park

Location: Frederick Road

18. Funeral director: Wm. Cook Inc.

Address: 1217 St. Paul St.

19. 7/28 (Date rec'd by registrar) 19 47 A. Hedrick M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 26 1947, at 4 30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1937 to July 26 1947 and that I last saw him alive on July 15 1947

Immediate cause of death	DURATION
Coronary Occlusion	5 Hours
Due to: Coronary Sclerosis	
Due to:	
Other conditions: Pulmonary Emphysema (Mild)	2 years

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: W. Stratton Hersperger M. D. or other

Address: 214 Medical Arts Bldg. Date signed: 7/26/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

CERTIFICATE OF DEATH

05849

Reg. Dist. No. 440

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 153 days

Hospital, Institution, or street address where death occurred:

Vets. Adm. Hosp., Fort Howard, Maryland

How long in hospital or institution? 153 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 728 Carroll Street

(If rural, give LOCATION)

2.(a) If veteran, name war: WW I

3.(a) FULL NAME: GEORGE W. STEWART

3.(b) Social Security Number: 215-01-0360

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband/or wife: ////

6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): 1-5-1888

8. AGE: Years	Months	Days	If less than one day
59	6	10	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business:

FATHER — 12. Name: Samuel Stewart; 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Josephine Wiggins; 15. Birthplace: Maryland

16. Informant: Clinical Records, Vets. Adm. Hosp.

Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 7/19/47 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery

Location: Baltimore, Maryland

18. Funeral director: Howard H. Blight Jr. Howard Blight Funeral Home

Address: 4914 Belair Rd., Baltimore, Md.

19. 7/12 1947 (Date rec'd by registrar) A.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 15 1947, at 6:15 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from February 12 1947 to July 15 1947 and that I last saw him alive on July 15 1947

	DURATION
Immediate cause of death: Cerebral hemorrhage, right	10 Hrs.
Due to: Arteriosclerosis generalized	Unknown
Due to:	
Other conditions: Arteriolonephrosclerosis	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: Substantiated above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of: .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Robert M. Cullison

R. M. CULLISON, M.D. CLIN. M.D. or other

Address: V.A.H. FORT HOWARD, MD. Date signed: 7-16-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

P.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

45 f

05850

Reg. Diat. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: BALTIMORE.

City or town: WOODLAWN

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 YRS.

Hospital, Institution, or street address where death occurred: Lehnert Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Woodlawn

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Lehnert Ave

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Roy E. STOUT

3.(b) Social Security Number: 216-10-6740

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Alice C Stout

6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): Jan 21st 1889

8. AGE: Years	Months	Days	If less than one day
58	5	16	...hrs. ...min.

9. Birthplace: Carrol Co. Md. (Town, county, and state)

10. Usual occupation: Cab Driver.

11. Industry or business: Yellow Cab Co.

FATHER — 12. Name: George Stout

13. Birthplace: Carrol Co. Md

MOTHER — 14. Maiden name: Carrie Eblaugh.

15. Birthplace: Carrol Co. Md.

16. Informant: Alice C. Stout.

Address: 6407 Lehnert ave. Woodlawn

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 10th 1947 (month) (day) (year)

Cemetery or crematory: Lorraine

Location: Balto. Co. Md.

18. Funeral director: William Cook Inc.

Address: 1217 St. Paul St.

19. July 8 1947 (Date rec'd by registrar) C. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 7th 1947 at 7:30 a. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1946 to July 7 1947

and that I last saw h... alive on June 4 1947

Immediate cause of death	DURATION
Cancer of Lungs	
Due to: Cancer of Tonsils	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: C. J. Schenck M. D. or other

Address: 210 Liberty Hts. Date signed 7/7/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

05851

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: (Catonsville)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? June 28th - July 1st
Hospital, institution, or street address where death occurred:
Opitz Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County:
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2717 N. Calvert St.
(If rural, give LOCATION)
2.(a) If veteran, name war: None ✓

3.(a) FULL NAME: Joseph Bernard Rudolph Suresch

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Willie Irene Suresch
6.(c) If alive, give age: abt 68 years

7. Birth date of deceased (mo., day, yr.): Aug. 23-1876

8. AGE: Years	Months	Days	If less than one day
70	10	8	..... hrs. ..... min.

9. Birthplace: Baltimore - Maryland (Town, county, and state)
10. Usual occupation: Retired - Tobacco & Candy
11. Industry or business: Store - owner.
FATHER 12. Name: Joseph Frank Suresch
FATHER 13. Birthplace: Alsace - Lorraine
MOTHER 14. Maiden name: Pauline Frederica Eppley
MOTHER 15. Birthplace: Germany
16. Informant: Daughter - Miss Adelina R. Suresch
Address: 2717 N. Calvert St. - City
17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 4 - 1947 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: Baltimore - Maryland
18. Funeral director: Stewart & Mowen Company
Address: 108 W. North Ave. - Balto. - 1 - Md.
19. 7/3 (Date rec'd by registrar) 19 47 [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 2 19 47 at 12:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 5 19 40 to July 2 19 47 and that I last saw h. 17 alive on July 1 19 47

Immediate cause of death	DURATION
Chronic Myocardial Degeneration	5 yrs +
Due to Arteriosclerosis	5 yrs +
Due to	
Other conditions Paralysis Agitans	4 yrs -

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: David Schneider M.D. M. D. or other
Address: 1101 N. Milton Ave. Date signed: 7-3-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9.45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05852

Reg. Dist. No.

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28 days

Hospital, Institution, or street address where death occurred:

Veterans Administration Hospital

How long in hospital or institution? 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 742 Wilmer Court

(If rural, give LOCATION)

2.(a) If veteran, name war: WW

3.(a) FULL NAME: JOSEPH SWEETWINE

3.(b) Social Security Number: 218-10-5636

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of husband or wife: ---

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 16, 1886

8. AGE:

Years	Months	Days	If less than one day
61	5	16	hrs. min.

9. Birthplace: Washington, D.C.

(Town, county, and state)

10. Usual occupation: Janitor

11. Industry or business

FATHER

12. Name: William Sweetwine

13. Birthplace: Washington, D.C.

MOTHER

14. Maiden name: Marie ?

15. Birthplace: Virginia

16. Informant: Clinical Records, Vets. Adm. Hosp.

Address: Fort Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 7-3-47 (month) (day) (year)

Cemetery or crematory: Private - Washington, D.C.

Location: Woodlawn Cem. Washington D.C.

18. Funeral director: William A. Jackson

Address: 916 Penna. Ave., Balto. Md.

19. 7/3 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 2 19 47 at 3:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 4 19 47 to July 2 19 47 and that I last saw him alive on July 2 19 47

Immediate cause of death	DURATION
TUBERCULOSIS, CHRONIC, PULMONARY, ACTIVE	Unknown
Due to:	
Due to:	
Other conditions: Abdominal Mass, Type Undetermined	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. H. Hunt O.D. + M.D.

M. D. or other

Address: V.A. Fort Howard, Md. Date signed: 7-2-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Reid v. S.
7/3/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06481 P.

Reg. Diat. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville 28, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 26 yrs., 9 mos., 15 das.

Hospital, institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 26 yrs., 9 mos., 15 das.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 905 N. Spring Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Grace M. Taylor

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
f	w	Married

6.(b) Name of husband or wife: William Richard Taylor

6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): 1882

8. AGE: Years	Months	Days	If less than one day
65	---	---	...hrs. ...min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Bottler

11. Industry or business: Factory

FATHER
12. Name: David Bailey
13. Birthplace: England

MOTHER
14. Maiden name: Elizabeth Brown
15. Birthplace: unknown

16. Informant: Hospital Records
Address: Catonsville 28, Maryland

17. Burial, cremation, or removal: Burial
Date thereof: 7/26/47 (month) (day) (year)
Cemetery or crematory: Baltimore
Location: Baltimore

18. Funeral director: Tillman & Son
Address: 1214 E. Cont St

19. July 24 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 22, 1947 at 12:12 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 7, 1920 to July 22, 1947 and that I last saw her alive on July 22, 1947

Immediate cause of death	DURATION
Left lower lobar pneumonia	12 hrs.
Due to: Sclerotic coronary disease	indef
Due to: Arteriosclerotic cardiovascular renal disease	indef
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M. D.
M. D. or other

Address: Catonsville 28, Maryland Date signed: 7/22/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information called for. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

48a 05853 ?

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:

County Baltimore

City or town Woodlawn
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred:
Rices Lane nr Windsor Mill Road

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Baltimore

City or town Woodlawn
(If outside city or town limits, write RURAL and give nearest town)

Street No. Rices Lane nr Windsor Mill Road
(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME Marie Louise Thomas

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife .....

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) January 18, 1912

8. AGE: Years	Months	Days	If less than one day
35	6	9	..... hrs. ..... min.

9. Birthplace Baltimore County, Md.
(Town, county, and state)

10. Usual occupation Physician Secretary

11. Industry or business .....

FATHER
12. Name Frank L. Thomas
13. Birthplace Baltimore County, Md.

MOTHER
14. Maiden name Anna L. Eichhorn
15. Birthplace St. Louis, Mo.

16. Informant Mr. Frank L. Thomas
Address Rices Lane, Woodlawn

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 30, 1947 (month) (day) (year)

Cemetery or crematory Lorraine Park Cemetery

Location Woodlawn, Md.

18. Funeral director E. W. Pomeroy

Address 4510 Liberty Heights Ave.

19. 7/29 (Date rec'd by registrar) 19 47 A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 19 47 at 6.55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 9 19 47, to July 27 19 47 and that I last saw her alive on July 27 19 47

Immediate cause of death	DURATION
Cancer of uterine cervix.	18 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Irvin Samber M. D. or other

Address 3003 Garrison Blvd. Date signed July 28, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

05854

Reg. Diat. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
House in the Pines, 16 Fusting Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 326 E. 25th St.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Lenore Wessels Thomson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W.	Widow

6.(b) Name of husband or wife: Late Albert W. Thomson
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 9, 1866.

8. AGE: Years	Months	Days	If less than one day
81	6	9	hrs. min.

9. Birthplace: Va.
(Town, county, and state)
10. Usual occupation: None
11. Industry or business

FATHER
12. Name: David Wessels
13. Birthplace: Va.

MOTHER
14. Maiden name: Nancy Aynes
15. Birthplace: Va.

16. Informant: Mrs. D. S. Trott
Address: 57 N. Prospect Ave. Catonsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 21/47. (month) (day) (year)
Cemetery or crematory: Western
Location: Edmondson Ave. & Longwood St.

19. Funeral director: Harry H. Nitsche
Address: 4101 Edmondson Ave.

19. July 21 19 47 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 18/47. 19 at 9 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 2 19 47, to July 18 19 47 and that I last saw h alive on July 15 19 47

Immediate cause of death	DURATION
Myocardial Insufficiency	3 mo
Due to Hypertension & Cardio-Vascular Disease	15 yr.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Wilmer K. Gallagher M.D. M. D. or other
Address: Catonsville 28, Md. Date signed 7-18-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

92d

Reg. Dist. No. 05855 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Opitz Home
How long in hospital or institution? 2 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1920 Eutaw Place
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: J. P. HENRY TIEDEMANN

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Caroline Tiedemann
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 21, 1855

8. AGE: Years	Months	Days	If less than one day
91	7	11	hrs. min.

9. Birthplace: Germany
(Town, county, and state)
10. Usual occupation: Retired Wool Buyer
11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace

MOTHER
14. Maiden name: Unknown
15. Birthplace

16. Informant: Mr. Albert Tiedemann
Address: 1920 Eutaw Place

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/5/47 (month) (day) (year)
Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.

19. 7/3 1947 (Date rec'd by registrar) Jno. H. Leach JM Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7/2/47 July 2, 19 47 at 12:30 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/1/47 19 to 7/1/47 19
and that I last saw h[illegible] alive on 6/23/47 19

Immediate cause of death	DURATION
Acute Endocarditis	4 years
Due to Senility	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Wm F. Sowers M. D. or other
Address: 10 E Madison Date signed 7/3/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. One correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 472

CERTIFICATE OF DEATH

05856

Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County 510 Bayside Drive Dundalk Md.

City or town (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? one Month

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County

City or town Dundalk Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 7322 Manchester Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war none

3.(a) FULL NAME Angelo Trotta

3.(b) Social Security Number 717-07-7180

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife late Rosaly Trotta

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept.11 1881

8. AGE: Years	Months	Days	If less than one day
65	10		hrs. min.

9. Birthplace Campagna Salerno Italy
(Town, county, and state)

10. Usual occupation Hostler

11. Industry or business Pensylvania R.R.

FATHER 12. Name Gelsomino Trotta

13. Birthplace Italy

MOTHER 14. Maiden name Donata Paradiso

15. Birthplace Italy

16. Informant Samuel O. Trotta (Son)

Address 510 Bayside Drive Dundalk Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 14 1947 (month) (day) (year)

Cemetery or crematory Oak Lawn

Location 7225 Eastern Ave

18. Funeral director Fraull Della Hoee

Address 52 N.Morley St.

19. 7/12 (Date rec'd by registrar) 1947 A.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 July 19 47 at 2.50 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 10 JUNE 19 47, to 11 JULY 19 47

and that I last saw h..m alive on 11 JULY 19 47

Immediate cause of death CANCER LUNG, RT. DURATION 7 MOS.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations INOPERABLE CANCER RIGHT LUNG Date of op. 25 JUNE 47

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Benjamin Highstein, M.D. M. D. or other

Address 121 S. HIGHLAND AVE Date signed July 11, 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

05857

P.

CERTIFICATE OF DEATH

Reg. Diat. No. 38

1. PLACE OF DEATH:

County Parkville

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
8901 Harford Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Parkville

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 8901 Harford Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Edward Lee Unglesbee

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Lillie

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 16, 1864

8. AGE: Years	Months	Days	If less than one day
82			hrs. min.

9. Birthplace Missouri
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name George W. Unglesbee
13. Birthplace Missouri

MOTHER
14. Maiden name Catherine Hein
15. Birthplace Missouri

16. Informant Mrs. Lillie Unglesbee
Address 8901 Harford Road, 14

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/9/47 (month) (day) (year)

Cemetery or crematory

Location Damascus, Md.

18. Funeral director Leonrd J. Ruck

Address 5305 Harford Road, 14

19. July 7 1947 (Date rec'd by registrar) A. W. Hesse Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6th, 1947 at 8:30 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 1 1947 to July 6 1947 and that I last saw him alive on July 5 1947

Immediate cause of death Myocardial Insufficiency

DURATION

Due to

Due to

Other conditions Arterio Sclerosis, Hypertension Angina Pectoris

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John A. Schaurich M. D. M. D. or other

Address 1337 S. Charles St Date signed July 7, 1947

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

06481 P.

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:
County Baltimore
City or town Arbutus
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? .....
Hospital, institution, or street address where death occurred:
4108 Leeds Ave.
How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Baltimore
City or town Arbutus
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4108 Leeds Ave Balto. 29
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3.(a) FULL NAME Harry Urbach

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Lina M. Urbach
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 26, 1881

8. AGE: Years	Months	Days	If less than one day
66	4	3	..... hrs. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual occupation Retired Police Sergeant
11. Industry or business Baltimore City

FATHER
12. Name Frederick Urbach
13. Birthplace Saxony, Germany

MOTHER
14. Maiden name Elizabeth Nordman
15. Birthplace Hanover, Germany

16. Informant Mrs. Lina M. Urbach
Address 4108 Leeds Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/1/47 (month) (day) (year)
Cemetery or crematory Parkwood Cem. Balto., Md.
Location .....

18. Funeral director WM. J. TICKNER & SONS
Address Balto., Md.

19. July 30 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 1947, at 7 45 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1947, to July 29 1947
and that I last saw h.. alive on July 28 1947

	DURATION
Immediate cause of death Cerebral Hemorrhage	2 days
Due to Essential Hypertension	?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....
Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Earl Pass, M.D. M. D. or other
Address 4001 Wilkens Ave Date signed 7-29-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

CERTIFICATE OF DEATH

05858

Reg. Dist. No. 44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Baltimore
City or town 2424 Lodge Farm Rd.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town 2234 Lodge Farm Rd.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Edgemere Md.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary Louise Olivier Venable

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C	M.

B.(b) Name of husband or wife Edward Venable
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 18-1888

8. AGE:

Years	Months	Days	If less than one day
59	3	15	hrs. min.

9. Birthplace Farmville Va.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Frank Reed
13. Birthplace Va.
MOTHER 14. Maiden name Martha Hall
15. Birthplace Va
16. Informant Helen Martin
Address 801 E Street Sparrows Pt.
17. B. (Burial, cremation, or removal. Which?) Date thereof 7-4-47 (month) (day) (year)
Cemetery or crematory Second Near Mt.
Location Farmville Va.
18. Funeral director Samuel W. Sullivan Jr
Address 1011 N. Arlington Ave.
19. 7/3 1947 A. No. Ledwick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2nd 1947 at 4:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1946 to July 1st 1947
and that I last saw h[illegible] alive on July 1st 47 19
Immediate cause of death Diabetes Mellitus — DURATION 2 yrs
Due to
Due to CMC
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. H. Thomas M.D.
M. D. or other
Address Turners Sta. Md. Date signed 7/3/47

Dr Martin Harwoodville Md

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

Reg. Dist. No. 05859 31

1. PLACE OF DEATH:
County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Queen Anne Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. Queen Anne Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William F Walker

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Clara E
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 23 1874

8. AGE: Years 72 | Months 9 | Days 29 | If less than one day ..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Carpenter Retired

11. Industry or business

FATHER 12. Name Clinton Walker
13. Birthplace Md

MOTHER 14. Maiden name Virginia Kaiser
15. Birthplace Md

16. Informant Clara E Walker
Address Queen Anne Ave. Catonsville Md

17. Disposition (Burial, cremation, or removal. Which?) Burial Date thereof 7/25/47 (month) (day) (year)

Cemetery or crematory Dunkard Assn
Location Frederick Co Md

18. Funeral director William Cook Jr
Address 217 E Pont St

19. 7/22/47 (Date rec'd by registrar) Wm E. Martin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 1947, at 7P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 20, 1947 to July 22, 1947 and that I last saw him alive on July 22 1947

Immediate cause of death Cerebral hemorrhage — DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE Wm E. Martin M. D. or other
Address Randallstown Date signed 7/23/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
[illegible] 2 1947
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 85

CERTIFICATE OF DEATH

05860

Reg. Diat. No. 38

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH

County Baltimore

City or town Towson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infant, give residence of mother)

State Maryland County Baltimore

City or town Towson

(If outside city or town limits, write RURAL and give nearest town)

Street No. 118 W. Susquehanna Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Arthur Newton Wastler

3.(b) Social Security Number —

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Feb. 23 1890

8. AGE: Years: 57 Months: Days: If less than one day: hrs. min.

9. Birthplace: Harford Co. Md.

(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER 12. Name: Newton S. Wastler

13. Birthplace: Frederick Co., Md.

MOTHER 14. Maiden name: Mollie Downey Fishburger

15. Birthplace: Washington Co., Md.

16. Informant: Floyd Wastler

Address: Providence Rd. Towson Md.

17. Burial (Burial, cremation or removal. Which?) Date thereof Aug. 4, 1947 (month) (day) (year)

Cemetery or crematory: Govans Presbyterian

Location: Baltimore, Maryland

16. Funeral director: John Burns & Sons

Address: Towson Md.

19. Aug. 1, 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31 1947, at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw him alive on ... 19...

	DURATION
Immediate cause of death: Toxemia & cachexia	5 wks +
Due to: Decubitus ulcers, both thighs	2 mo
Due to: Paralysis, right side, cause unknown	5 yrs
Other conditions: Epilepsy	57 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...

Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE Rollin C. Hudson M.D. D.M.E.

M. D. or other

Address Towson Md. Date signed 7/31/47


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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06482 P.

83a BC

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A25

1. PLACE OF DEATH:

County Baltimore

City or town Baltimore - 12 11th

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 months

Hospital, Institution, or street address where death occurred:

Md. C. Memorial Nursing Home

How long in hospital or institution? 6 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County .....

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. Blackstone Apts

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME FLORENCE WARD Wheeler

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife William B. Wheeler

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) December 19, 1870

8. AGE: Years	Months	Days	If less than one day
76 77	7	12	..... hrs. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name John J. Ward

13. Birthplace Maryland

MOTHER 14. Maiden name Julia A. Weaver

15. Birthplace Maryland

16. Informant Mr. N. Irvin Gressitt

Address 1102 Fidelity Bldg.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 2, 1947 (month) (day) (year)

Cemetery or crematory Greenmount Cemetery

Location Baltimore, Md.

18. Funeral director Miller & Amoreau

Address 4510 Liberty Heights Ave.

19. 8/2 1947 (Date rec'd by registrar) G. W. Fedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31, 1947 at 8:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 12, 1947, to July 31, 1947 and that I last saw h.e.r. alive on July 31st, 1947

Immediate cause of death	DURATION
Cardio-respiratory failure	
Due to Cerebral Embolism	
Due to	
Other conditions Chronic Myocarditis	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Robert H. Young, Jr. M.D. M. D. or other

Address 5411 Yorktown Road Date signed 7/31/47

05861

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 52 L

CERTIFICATE OF DEATH

Reg. Dist. No. 42

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore County

City or town: Relay, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 38 Years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Relay, Md
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1473 Rolling Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME CHARLES HOOVER WHITE

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Adeline Duvall

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 1, 1881

8. AGE:

Years	Months	Days	If less than one day
65	11	11	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: B&O.R.R. Freight Rep.

FATHER
12. Name: John Alexander White
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden name: Addie Davis Hoover
15. Birthplace: Washington, D. C.

16. Informant: Mrs Charles Hoover White

Address: 1473 Rolling Rd, Relay 27, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/15/47 (month) (day) (year)

Cemetery or crematory: Loudon Park Cemetery

Location: Baltimore, Maryland

18. Funeral director: H. H. Mears and Son.

Address: 805 W. Calvert Street.

19. July 14 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 12 1947, at 3:45 p M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1946 to July 12 1947

and that I last saw h... alive on July 12 1947

Immediate cause of death	DURATION
Uraemia — C	4 days
Convulsions	
Due to Carcinoma bladder	2 yrs
Cystectomy & Trans-plantation	
Due to ? Kidneys with Lower Bowel	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma bladder.

Date of op. /

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Frederick V. Reuter M. D. or other

Address: 723 Medical Arts Bldg Balto Date signed: 7-14-47


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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9.45.15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:
County: Baltimore
City or town: English Consul
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 3247 Magnolia Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto
City or town: English Consul
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 3247 Magnolia Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Joseph Earl Willhide Sr.
3.(b) Social Security Number: 212-05-8219

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Ida E. Stiles
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Dec 12, 1890
8. AGE: Years 56 Months 7 Days 6 If less than one day ... hrs. ... min.
9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Glass worker
11. Industry or business: Swindel Brothers
FATHER 12. Name: Ellsworth S. Willhide
13. Birthplace: West Virginia
MOTHER 14. Maiden name: Wenona Hammond
15. Birthplace: Md
16. Informant: Mrs Ida E. Willhide
Address: 3247 Magnolia Ave
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 7/22/47 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: 3801 Frederick Ave.
18. Funeral director: Harry H. Witzke
Address: 4101 E. Edmondson Ave
19. July 19 47 (Date rec'd by registrar) Ge Kieffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 18 1947 at 8-30 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Coronary occlusion	
Due to	
Due to	
Other conditions: sudden death enquiry	

(Include pregnancy within 3 months of death)
Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: Geo M. Kieffer, Dep. Med. Exam. Balto Co. M. D. or other
Address: 1010 Leeds Ave Date signed: 7-19-47

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

05863

CERTIFICATE OF DEATH

Reg. Dist. No. 35

1. PLACE OF DEATH

County Baltimore

City or town White Hall

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 48 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore

City or town White Hall

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John Mitchell Wilson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Ella M. Wilson

6.(c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) March 2 - 1872

8. AGE:

Years	Months	Days	If less than one day
75	4	12	...hrs. ...min.

9. Birthplace White Hall Md.

(Town, county, and state)

10. Usual occupation Retired mail caller

11. Industry or business

FATHER

12. Name James P. Wilson

13. Birthplace White Hall Md.

MOTHER

14. Maiden name Annie Norris

15. Birthplace White Hall. Md.

16. Informant T. Herbert Lytle

Address White Hall. Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof July 16-1947 (month) (day) (year)

Cemetery or crematory Vernon

Location White Hall. Md.

18. Funeral director Howard S. Markline

Address White Hall. Md.

19. July 15, 1947 (Date rec'd by registrar) Mrs Howard S. Markline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14 1947, at 9.30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 1945 to July 14 1947 and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Coronary Thrombosis	2 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Milnor Bortner M.D. M. D. or other

Address White Hall Date signed July 15 47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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JUL 18 1947.
BUREAU OF R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05864

932

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Balto.

City or town Colgate

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 500 S. 46th. St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.

City or town Colgate

(If outside city or town limits, write RURAL and give nearest town)

Street No. 500 S. 46th. St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Anna B. Wolf

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	widowed

6.(b) Name of husband or wife Nicholas John Wolf

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 5 - 1869

8. AGE:

Years	Months	Days	If less than one day
78	9		..... hrs. ..... min.

9. Birthplace Germany (Town, county, and state)

10. Usual occupation At Home

11. Industry or business —

FATHER

12. Name Henry Blankner

13. Birthplace Germany

MOTHER

14. Maiden name Unknown

15. Birthplace

16. Informant Mrs. James Aires

Address 500 S. 46th. St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/16/47 (month) (day) (year)

Cemetery or crematory Oak Lawn

Location Eastern Ave Essex 21, Md.

18. Funeral director John B Connelly

Address 418 Eastern Ave. Essex 21, Md.

19. 7/14/47 (Date rec'd by registrar) John B Connelly. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13 1947 at 4:30 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 1946 to July 13 1947

and that I last saw her alive on July 13 1947

Immediate cause of death	DURATION
Arterio-Sclerotic Cardio-Vascular disease	3 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op.

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James F. White, M.D. M. D. or other

Address 760 Eastern Ave. Baltimore 24, Md. Date signed 7/14/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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JUL 15 1947
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05865

48 b

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH
County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. Old Frederick Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Susan E Wolfe

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Wm H. Wolfe
6.(c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) August 1st 1882

8. AGE: Years 58 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Domestic
11. Industry or business Housework

FATHER
12. Name Michael Meehan
13. Birthplace Ireland

MOTHER
14. Maiden name Mary E. Jones
15. Birthplace Maryland

16. Informant Mrs Mary E. Smith
Address 2826 Fredrick Road

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-8-1947 (month) (day) (year)
Cemetery or crematory New Cathedral
Location Baltimore

18. Funeral director Edw. J. MacNabb
Address Catonsville - Md.

19. 7-7 1947 (Date rec'd by registrar) Harry L. Maffie Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6 1947 at 1.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 17 1947 to July 6 1947 and that I last saw h[illegible] alive on July 5 1947

Immediate cause of death	DURATION
Hemorrhage from Intestines	6 mo
Due to Metastasis of Intestines and Mesentery	6 mo.
Due to Ca of intestines	1 yr.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Wilson K. Gallagher M.D.
M. D. or other
Address Catonsville 28, Md. Date signed 7-7-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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JUL 9 1947
BUREAU V. R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05866

Reg. Diat. No. 44

1. PLACE OF DEATH:
County: Baltimore
City or town: Essex, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Essex
(If outside city or town limits, write RURAL and give nearest town)
Street No. 511 Essex Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Ella Virginia Woodward.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married.

6.(b) Name of husband or wife: Joseph R. Woodward
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 30th 1885

8. AGE:	Years	Months	Days	If less than one day
	61	9	9	hrs. min.

9. Birthplace: Baltimore Md (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: At Home

FATHER
12. Name: Wm. Thomas Wellen
13. Birthplace: Balto Md

MOTHER
14. Maiden name: Mary Wollenslager
15. Birthplace: Balto Md

16. Informant: Mrs. Woodward (Son)
Address: 511 Essex Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/23/47 (month) (day) (year)
Cemetery or crematory: Friedenridge
Location: Frederick Rd
18. Funeral director: Jno G Connelly
Address: 418 Eastern Ave

19. 7-23-47 (Date rec'd by registrar) Jno G Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 21 19 47, at 9:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19
and that last saw h alive on 19

Immediate cause of death	DURATION
Coronary Occlusion	
Due to Myocarditis Chronic	5 yr.
Due to Hypertension	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: None Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: R. B. Davis M.D.
Medical Examiner, Baltimore Co. Md.
Address: Dundalk, Md. Date signed 7/24/47

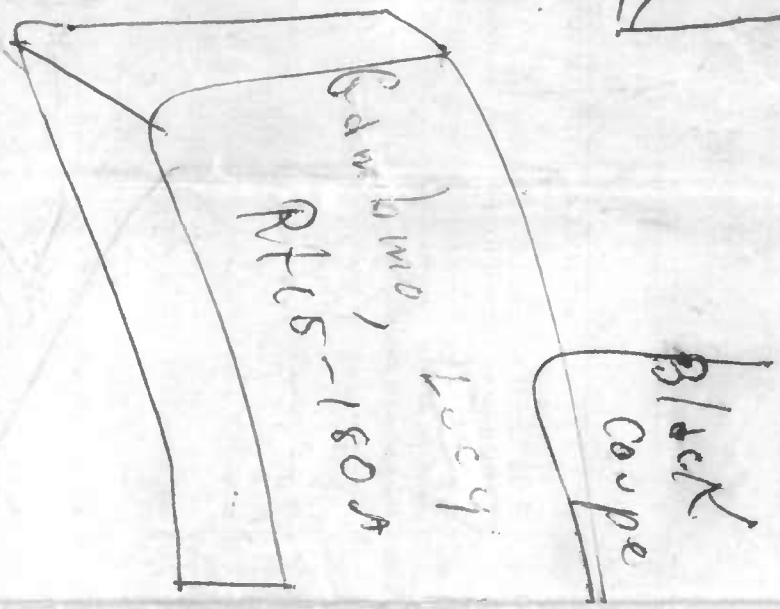
VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

George Guttenbergen

392-909 500



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05867

Reg. Dist. No. 41

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard, Md. (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 days
Hospital, institution, or street address where death occurred: Vets. Adm. Hosp. Ft. Howard, Maryland
How long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. 2244 Fleet Street (If rural, give LOCATION)
2.(a) If veteran, name war: WW II

3.(a) FULL NAME: VINCENT YEROMIN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: Single
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 7-20-1902

8. AGE: Years	Months	Days	If less than one day
44	11	20	hrs. min.

9. Birthplace: Poland (Town, county, and state)
10. Usual occupation: Paper Hanger
11. Industry or business:

FATHER
12. Name: Filix Yeromin
13. Birthplace: Poland

MOTHER
14. Maiden name: Anna Youthski
15. Birthplace: Poland

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/15/47 (month) (day) (year)
Cemetery or crematory: Holly Rosary Cemetery
Location: German Hill Road.
18. Funeral director: Howard H. Blight Jr. Howard Blight Funeral Home
Address: 4914 Belair Rd., Baltimore, Md.

19. 7-11-47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 10 19 47 at 7:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 27 19 47 to July 10 19 47 and that I last saw h im alive on July 10 19 47

Immediate cause of death	DURATION
TUBERCULOSIS, PULMONARY, Far Advanced, Right	4 mos. plus
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Robert M. Cullison
R. M. CULLISON, M.D. CLIN. M.D. or other
Address: V.A.H. FORT HOWARD, MD. Date signed 7-11-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M